			1 - State Registrar	State of Maryl	and / Depa <i>Cel</i>	artment of rtificate of	Health and Death		giene Reg. No.	2004	14501
			1. Decedent's Name (First, Middle, Las	t)				2. Date of De. Month	ath Day	Yeer	3. Time of Death
	Physicia /Medic		John Adams Grant					April 1	2, 2	2004	11:09 a.M
	Examin		4e. Facility Name (If not institution, give				or Location of D	eath		County of Deel	h
			Chester River Host  5. Social Security Number 6. Se		yrs. last birthday)		ertown	Hrs. 8. Date of Birt		Kent 9 Bir	hplece (State or Foreign
	Funeral Director		178-24-9529	7. Age (In )	71 Yrs.	Months Day		12/04/3	932	Pen	nsylvania
			Usuel Residence of Decedent								
	how		10a. State 10b. County	10c.	. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Ma Sa-f s	cto	Maryland Kent		Chester				10 011	/ 11 m . O	
	with the	Dire	10e. Street and Number 5880 Langford Bay	Road		10f. Zip Code	ertown		•	en of What Co JSA	ountry ?
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Directo	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent o	Hispanic Origin	? (Specify Yes or No		4. Race - Ame	
^	fter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, specify Ci	iban, Mexican, P	uerto Rican, etc.)	}	Black, Whit Specify: W	
5	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 Yes 2LAN	o Specify:			Specify: iV	ште
9500-6121	Within 72 hours after death with the Marylan piene. Than "natural", or tiems 23a or 28a-f show the Madical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	e during most of	working	16b. Kin	nd of Business	Industry
	within	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	1	Physicia	•		Puh	olic He	alth
מ	다 다 나		17. Father's Name (First, Middle, Last)			. 11) 03 020		Name (First, Middle			
<u>a</u>		To Be	Albert Mathias Gra	int			Mary A	dams		_	
Maryland 2	is 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (			-		r Rural Route Numb			
-	and 2 ealth m 27		Betty Ann Grant/ V		Db. Place of Dispo		і вау ко	ad, Cheste		n, MD	
0	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □	Removal from State	cemetery, cre	matory or other p			9		nsville, MD
Baltımore,	it. Pa intmen intant injury		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen								
Ba	permit. Pages 1 Department of H Important: If its any injury or ott		Mich NO	delas	13	llows, l O Speer	lelienbe Road, C	in & Newna hestertown	ım Fu ı. Mə	neral ryland	Home P.A. 21620
r	2,5		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the							Approximete Interval Between
	Physician		Immediate Cause (Final disease or condition	PANCE	LEATIC	- CAN	CER				4 months
0	/Medical Examiner		resulting in death)	Due to (or as a cor							
b	Examine	<u></u>	Sequentially list conditions,	b. Due to (or as a cor	nsequence of):						
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000 10 (01 20 2 00							
,	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):						
8760,	ate be executed obysician and the burial-transit	dical	(	d							
9	ing ph	Med	IF FEMALE:		A 2 12 1						
Вох	leat certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time	Fetal death 3	□Ectopic pregna □ Other (specify)			2	3d. Date of de Month	Day Year
P.0.	he de	ysic	1 Yes 2 No	9☐ Unknown	ordean 5	_ Other (specify)					
مز	uires that the de signed by the a Id be detached f	Completed by Physician/Me	Part II. Other significant conditions of	ontributing to death but no	t resulting in the t	underlying cause	given in Part I.	23e. Did	obacco u	se contribute t	o the cause of death?
rds	quires in sign	q pe	TYPE Z DI	ABETES				_ 10	Yes 2	No 3□P	robably 4 DUnknown
000	aw requir is been si 2 should	piet						24a. Was		24b. Were a	utopsy findings available completion of cause of
Œ.	The lay ate has page 2	Com						perfo	ormed?	death? 1 ☐ Yes	30 No
/ita	icien: Th ceruficate rectir, pag	Be (	25. Was case referred to medical examiner?	Hospital:			Oth or	Death (Check only			
of	Physi this c al dire	10	1 ☐ Yes 2☑No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	INT 3 DOA	Other: 4   Nursi	ng Home 5 Res. 28d. Describe			acify)
OU	ding h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Day Yes		\	Vork? □Yes 2□No				
Division of Vital Records,	or Attending Physicient. The law requires that the deati certific ther death.  Director: After this certificate has been signed by the attending p in by the funeral directifit, page 2 should be detached for use as	ifica	3 Suicide 6 Could not b	e 28e. Place of Injury -	At home, farm, s	treet, factory, offi	Ce Ce	28f. Location (			ural Route Number,
á	s after s after at Dire	Certification:	4  Homicide	building, etc. (S	рөспу)			Only of 10	mi, otato,		
	To the Hospital or Attending Physicism: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral directir, page 2		29a. Certifier   1 ertifying Ph (Check only 2 Medical Example)	nysician: To the best of my miner: On the basis of exa	y knowledge, dea mination and/or i	th occurred at the	time, date and p y opinion, death	place, and due to the occurred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the Pwithin 2-	Medical	one) 29b. Signature and title of certifier	and manner stated.			ense number			e signed (Mon	
	Wil To		230. Signature and site of certified	Milen	w		04158	7	4	131	2004
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)				1 -	
			Helen A. Noble,	122 Speer Ro	ad, Ches	tertown	, Maryla	nd 21620			
-	St	ate	31. Date filed (Month, Day, Year)	32. egistrar's	Signature	Carelle 1					

DHMH 17 Rev 1/2001

ORIGINAL

	•	For State Registrar	State of Ma	ryland / Dep		Health and I	Mental Hyg	iene	004	1450
Physici		1. Decedent's Name (First, Middle, Las Annie		Haraway			2. Date of Deat Month April	Day 19,	Year 2004	3. Time of Death  2:45 A <sup>M</sup>
/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, Annapo	or Location of Death	1	1	nty of Death nne Ari	undel
Funeral Director		226-26-1425		(In yrs. last birthday	-	If Under 24 Hrs.	8. Date of Birth (Month, Day, Aug. 11	Year)	9. Birthp	lace (State or Foreign
-f show	tor	Usuel Residence of Decedent  10a. State  10b. County  Maryland Prince G	eorges	10c. City, Town or I	Location				1	0d. Inside City Limits
berott	Director	10e. Street and Number			10f. Zip Code	715		0g. Citizen	of What Cour	ntry?
Department of Health and Mental Ptyglene. Important: If item 27 is marked other than "netural; or items 23e or 28e-f show say injury or other traumatic event, I'm Medical Exactin at maal be notified at once.	by Funeral	12700 Millstream  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	ver in U.S. 13		Hispanic Origin? (S oan, Mexican, Puert		14. F	Race - Amend Black, White,	
n "natura Medical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5-	(Giv	edent's Usual Occu ve kind of work done DO NOT use retire	during most of wor	rking	16b. Kind o	f Business/In	dustry
Il Hygiene other tha vent, It a	Be Com	17. Father's Name (First, Middle, Last)	2		maker	18. Mother's Nan	ne (First, Middle, i	Own Maiden Sun		
Menta Parked Patic e	To E	John Washington		40h 14a	iliaa Addusaa /Stma	Annie	Kate	Har		Code
ilth and 27 is п г trauп		19a. Informant's Name/Relationship ( Ralph Haraway/ Hu				eam Drive				20715
ant of Hea at: If item y or otha		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specific	Removal from State	20b. Place of Discometery, cr	position (Name of rematory or other placematory				on-City or To	
Department Importar any injur		21. Signature of Puneral Service Licer			22. Name and Addr	ess of Facility Ro	bert E.	Evans	Funer	
ysician Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	9.	nter the mode of dy	ing, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
ysician and le burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
ed by the attending phys detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ØNo 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	3 ⊟Ectopic pregnand 5 ☐ Other (specify)	cy		23d.	Date of delive	ery Day Year
5 8	þ	Part II. Other significant conditions of	contributing to death bu	t not resulting in the	underlying cause g	iven in Part I.		bacco use d es 2□Ne		ne cause of death? pably 4 ZUnknow
ate has been si page 2 should	Completed						24a. Was a autops perior	sy med?	lb. Were auto prior to co death? 1  Yes	psy findings availab mpletion of cause of 2 No
this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:	nt 2 ER/Outpati	ient 3 DOA	thor	ath (Check only or		Other (Specif	iv)
After fune	I	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inju		28d. Describe h			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
24 hours after deatl Funeral Director: etely filled in by the	Certification;	3 Suicide 6 Could not be determined		ry - At home, farm, . (Specify)	street, factory, office	•	28f. Location (S City or Town		umber or Rura	I Route Number,
within 24 hours after deatl  To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Example)	nysicien: To the best of miner: On the basis of and manner sta	examination and/or ted.	investigation, in my		urred at the time, o	late and pla		the cause(s)
To		V	rolBech,		D	46052		4/	19/04	
		30. Name and address of person who			e. Print Ouhw	ay aun	a polis,	MO		
St	ate	31. Date filed (Month, Day, Year)	62	r's Signature	South 1					

			1 - For State Registrar		te of Mar	yland / [		artment tificate					Reg. No.	200		+503
	Physicia /Medic		Decedent's Name (First, Midd     Maria Honoria		·a							2. Date of Dea Month April	Day	2004		of Death 55 a.m
	Examin		4a. Facility Name (If not institution	n, give street a	nd number)			4b. City,	Town, or	Location o	of Death		4c. C	ounty of De	ath	
	1		Randolph Hill						eato					ontgor		
	Funeral Director		5. Social Security Number 213-56-9738	6. Sex 1 ☐ M 21	21 =	In yrs. last bii 90	rthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min	8. Date of Birt (Month, Day Aug. 6,	v Yearl	1 (	irthplace (State Country) gentin	-
ore, maryland zizio-0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Insportment of Health and Mental Hygiene. Insportment if it is an 21st marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avant, it a Maclical Exist it are marked excitited at once.	To Be Completed by Funeral Director	Usual Residence of Decedent	oshire  12. Wa Am Tried If Y Ye.  Col  Last)  Ship (Type, Prii  ws/ Dat	Avenue, s Decedent Evened Forces? I/ves 2 IN No es, Give ar or Dates: lieted) lage (1-4or 5+) nt) aghter	Oc. City, Tow Silve Apt. er in U.S.  16a	310 13. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	pring 10f. Zip 2 Nas Decede (Yes, spec 12 Yes 2 dent's Usua kind of wor DO NOT us 2 make 1	Oode  0906  ont of Histy Cubas  ont of Histy C	spanic Orin, Mexican Specify:  tation luring most  18. Mothe Mar and Number	gin? (Special Power of Arge:  t of working or Summer or Rura  t, S	ncify Yes or No- Rican, etc.) ntinian	10g. Citize  U  16b. Kinc  Or  Maiden S  or, City or  20c. Loca	en of What CISA  4. Race - An Black, Who Black, Who Home Currame)  Town, State  MD  ation - City City	10d. Inside 1  Ye Country?  nerican Indian, hite, etc.  11te s/Industry  ne 20902 or Town, State	City Limits
Dallimor	permit. Page Department of Important: If any injury or once.		1 ⊠Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other ( 21. Signatur of Funeral S vice	Specify)	Cole	Gate	Cem	Heav etery	en d Addres	s of Facilit	2C	Funera			ring, M	
8700,	Cate be executed which is the burial-transit the burial-transit to the property of the propert	dical Examiner	23a, Part1. Enter the disease, of shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Me	be on each line  Lastat  Due to (or as a  Due to (or as a	Lc Cane consequence	cer of):			9, 3441 45		, copinatory a			Approxim Interval E Onset an 1 Yea	Between Id Death
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cords, r	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant condit	ions contributii	ng to death but	not resulting	in the u	nderlying c	ause give	en in Part I					to the cause of Probably 4	
ř	The lay ate has page 2	Completed					·							24b. Were prior to death		gs available of cause of
VII	ysician: Th is certificate director, paç	Be	25. Was case referred to medic examiner?	al Hospita	1-				Oth	200	-	(Check only o				
_	Signal Si	tion: To	1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pend 2 ☐ Accident inves	28a	" 1 ☐ Inpatient . Date of Injury . (Month, Day)	28b.	utpatier Time o Injury		8c. Injury Work	4 22 140		me 5 Residente la			pecify)	
DIVISI	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could	Loot bo	Place of Injur- building, etc.	y - At home, f (Specify)	arm, str	eet, factory	, office		Ī	28f. Location (3 City or Tox	Street and wn, State)	Number or	Rural Route N	umber,
	he Hospi n 24 hour ha Funar sletely filli	Medical		I Examiner: O		xamination a						and due to the ed at the time,				Θ(S)
	To t To tl	Σ	29b. Signature and title of certif	er	C	25	1	290		number					nth, Day, Year	-)
	VL.		Meite		- She	yel !	( )		D0	8944			Apri	1 19,	2004	
	٦		30. Name and address of perso		_				, .		77		3.0	D 000	O.F.	
77	O.		Martin C. Sh. 31. Date filed (Month, Day, Yea		.D. 32. Registrar		:U F	arrag	ut A	venue	e, Ke	ensingto	on, M	ע 208	95	
360	Sta Regist	ate rar	APR 2 (		Saner	رسم	9	do	216							

79			State of Maryland /		alth and Mental Hy	
			Decedent's Nama (First, Middle, Last)	COMMODIC OF D	2. Data of De	eeth 3. Time of Death
- Andrew	Physic /Medi	cal	MARGARET ROSE HAMM  4a Facility Nama (If not institution, give streat and number)	4b. (	Month APRII City, Town, or Location of Daal	
A. A.	Exami	ner	5165 BRADDOCK ROAD		WOODBINE	CARROLL
	Funeral		5 Social Security Number 6 Sax 7 Aga (In vrs. last t	oirthday) If Undar 1 Year If		rth 9. Birthplace (State or Foraign
	Director		217-40-7412 1 M 2 F 61	Yrs. Months Days I	MARC	9. Birthplace (State or Foraign Country) H 31, 1943 WEST VIRGINIA
	p.		Usual Rasidence of Dacedant  10a. Stata 10b. County 10c. City, To	wn or Location		10d. Insida City Limits
	within 72 hours after death with the Maryland ene. than "natural; or items 23a or 28a-f show ha Madical Examiner must be notified at	5	W	DDBINE		1 ☐ Yas 2 <b>X</b> No
	the N	Director	MARYLAND CARROLL WCC	10f. Zip Coda		10g. Citizan of What Country?
	3a or		5165 BRADDOCK ROAD	21797	7	UNITED STATES
	death	ner	11. Marital Status 12. Was Dacedant Ever in U,S. Armad Forcas?	13. Was Dacadant of Hispa If Yas, specify Cuban, I	anic Origin? (Spacify Yas or N Maxican, Puarto Rican, etc.)	o- 14. Race - Amarican Indian, Black, White, etc.
20	or the	F	1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yas 2 ☐ No If Yas, Giva		Specify:	Spacify: WHITE
21215-0020	hours ural',	Completed by Funeral	3 ☐ Widowad 4 ☐ Divorced Yaar or Datas:	a. Decedant's Usuel Occupation	20	16b. Kind of Business/Industry
15	in 72	iete	(Specify only highast grada complated)	(Giva kind of work dona duri lifa. DO NOT use retired)	ing most of working	Too. Kind of Business madely
212	with liene.	E O	Elamantary/Secondary (0-12) Collega (1-4or 5+)	CERTIFIED NU	JRSING ASSISTAL	T PRIVATE DUTY
	e filed of hygie	Bec	17. Fathar's Nama (First, Middla, Last)	18	B. Mothar's Nama (First, Middle	
la	should be ind Mentel merked o	To	ROY RODNEY FURROW, JR.		DOROTHY PHYLI	LIS MADLOX
Maryland	2 sho and I		(1,7,2)			par, City or Town, State, Zip Coda)
	1 and 2 Health em 27 i		TAMMY C. DEBENEDICTIS/DAUGHTER	of Disposition (Alama of	RD, WOODBINE,	MD 21797 20c. Location - City or Town, Stata
Baltimore,	S		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	CREEN MEMORIA	L GARDENS 04/16	FINKSBURG, MARYLAND
Ξ	it. Pertant		4 Donation 5 Other (Specify)  21. Signature of Funeral Sarvice Licensaa	22. Nama and Address of	J GROUPIN	Timeboney Timebone
Ba	permit. Pege Depertment of Important: if any injury or once.		Just & Dento	MYERS-DURBOR 91 WILLIS S	RAW FUNERAL HOI STREET, WESTMI	NSTER, MD 21157
	- 1		23a. Part I. Enter the disaasa, or complications that caused tha daath. Do shock, or heart failura. List only one causa on aach line.	o not enter tha moda of dying, s	such as cardiac or respiratory	arrest, Approximate Interval Batween Onsat and Death
	Physician /Medical Examiner		Immediate Causa (Final disaase or condition resulting in death)		Concer	/ig
Н			Due to (or as	a consaquanca of):		
	uted 1 ansit	cal Examiner	b	a consequence of):		
Ć	exect an end rial-tre	Exa	Sequentially list conditions, if any, leading to immediate cause. Entar Undartying Cause (Disease or injury	g consequence oij.		1
68760,	te be ysicia		Cause (Diseese or injury that initiated avents resulting in death) Last	a consaquance of):		
89	ing ph	Med	resulting in obath) cast			
Box	ath ca ttendi or use	ian	d			
_	The law requiras that the death cartificate be executed at has been signed by the attending physician end paga 2 should be datached for use es the burial-trensit	by Physician/Med	Part II. Other significant conditions contributing to death but not rasulting	in tha undarlying ceuse givan		tobacco usa contribute to tha cause of death?
P.0.	that the ed by datac	P.			1	Yes 2□ No 3□ Probably 4☑ Unknown
Records,	uiras n sign lld be	d b				s an autopsy 24b. Were autopsy findings available prior to
8	w require been si should	Completed			pan	ormad? available prior to completion of cause of death?
Re	he lay a has aga 2	E O			10	Yes 214No 1 Yes 2 No
Vital	an: T tificet tor, p	Be C	25. Was case referred to medical	2	26. Place of Death (Check only	one)
of V	Physician: this certific	T0	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	Outpatient 3 DOA Other:	4□ Nursing Homa 5 Mes	idence 6 Othar (Spacity)
0 [	ng Ph fter th merel		27. Manyfer of Death 1 ☑ Natural 5 ☐ Panding 28e. Data of Injury (Month, Day Yaar)	o. Tima of 28c. Injury at Work?		how injury occurred
Division	Attending or death. ector: After by the fune	Certification:	2 Accident investigation		s 2 No	(Streat and Number or Rural Route Number,
Ξ	or Att	ŧ	3 ☐ Suicida 4 ☐ Homicide  3 ☐ Souid not be dataminad  4 ☐ Homicide  3 ☐ Souid not be dataminad  28e. Pleca of Injury - At homa, building, atc. (Specify)	rarm, straat, factory, office		own, Stata)
	ours sours and filled	2	29a. Cartifiar 118 Certifying Physician: To the best of my knowlad	ga, daath occurred at the tima,	date and place, and dua to the	e cause(s) and manner as stated.
	To the Hospital within 24 hours: To the Funeral completely filled	edicai	(Check only one)  2 Medical Examiner: On the basis of examination of and mannar steted.	end/or invastigation, in my opini	ion, daath occurred at the time	, date and place, and due to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificeta has completely filled in by the funeral director, paga 2	Me	29b. Signature and titla of certifiar	29c. Licansa n	numbar	29d. Data signed (Month, Day, Year)
	now		John Middleton	D2	-5443	4/12/04
	Ug		30. Nama and addrass of person who complated causa of daath (Itam 23e	(Type, Print)		11
22				POOLE ROAD, WES	STMINSTER, MD	21157
7	St Regist	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signatura  APR 1 4 2004	M. Sand.		
	1.09101		WIN TH COOL MANAGED IN	- July - Charles		

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

### Flease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registra@MFND#4aperMF4	State of Maryland		cate of Deat		Reg. I	200	4 11.5					
Decedent's Name (First, Middle, Last					ate of Death		3. Time of De					
Steve Richard He	nrv			AP	RIL 9,2	004 Year	9:16p					
4a. Facility Name (If not institution, give	street and number)	4b.	City, Town, or Location	on of Death		c. County of Dea	th					
INDEPENDENCE STREE	Parkland	RIVE W	HEATON		M	ONTGOMER	Ϋ́					
5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday) If U	Jnder 1 Year   If Und	der 24 Hrs. 8. Da	ate of Birth	9. B <u>i</u> r	thplece (State or F					
579-90-1757	ØM 2□F 34	Yrs. Mor	nths Days Hour		Nonth, Day, Yea J. 5, 19		o <i>untry)</i> ` naica					
Usual Residence of Decedent				1110	v • •	000 001	iid A C Ci					
10a. State 10b. County	10c. City	, Town or Location	n				10d. Inside City					
Maryland Montgom	erv Mon	ntgomery	Village				1 ☐ Yes 2					
10e. Street and Number			of. Zip Code		10g. (	Citizen of What Co	ountry?					
19800 Bazzellton	Place		20886			USA						
11. Marital Status	12. Was Decedent Ever in U.	S. 13. Was [	Decedent of Hispanic , specify Cuban, Mexi	Origin? (Specify Y	es or No-	14. Race - Ame						
1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 XNo				, etc.)	Black, Whit						
Maryland Montgom  10e. Street and Number  19800 Bazzellton  11. Marital Status  1 □ Never Married 2 ⅓ Married  3 □ Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	If Yes, Give Year or Dates:	1UY	′es 2⊠ No <i>Spec</i>	ify:		Specify: B1	ack					
15. Decedent's Edu	ucation	16a. Decedent's	Usual Occupation		16b.	Kind of Business	/Industry					
(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind o life. DO N	of work done during m OT use retired)	lost of working								
12	College (1-401-34)	Lands	caper		] ]	Lawn Card	2					
17. Father's Name (First, Middle, Last)			18. Mc	other's Name (Firs	t, Middle, Maid	en Sumame)						
Cornel L. Henry			Į į	Eleanor R	ath Mui	rav						
19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailing Ad	dress (Street and Nur				Zip Code)					
Cornel L. Henry/			han Road,									
20a. Method of Disposition	20b. P	lace of Disposition				Location - City or						
1 Burial 2 ☐ Cremation 3 ☐ F	Hemoval from State   Ga	emetery, crematory ate of He		April 2	-							
*4 □ Donation 5 □ Other (Specify)	)	Cemete	ry	1	Sil	ver Spri	ing, MD					
21. Signature of Funeral Service Licens	999	Fran	me and Address of Fa CIS J. Col	lins Fun	eral Ho	ome Inc.						
Carnes SV	Jakay	500 1	University	Blvd. W	Silv	er Sprin	<u> </u>					
23a. Part1. Inter the disease, or comp shock, wheart failure. List only o	lications that called the death	Do not enter the	mode of dying, such	as cardiac or resp	piratory arrest,		Approximate Interval Betwe					
Immediate Cause (Final disease or condition	Dr. 1++	1.					Onset and Dea					
resulting in death)	a. Due to (or a consequ	uence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury)	Due to (or as a consequ	uence of):										
cause. Enter Underlying Cause (Disease or Injury) that initiated events												
resulting in death) Last	Due to (or as a consequ	ience of):										
	d											
_												
		·	Due to (or as a consequence of):									
IF FEMALE:	23c. If yes, outcome of pregna	ncy				23d. Date of de	livery					
23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal	death 3 Ecto	ppic pregnancy			23d. Date of de Month	livery Day Yea					
23b. Was decedent pregnant		death 3 Ecto	pic pregnancy er (specify)									
23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ecto	er (specify)	ırt I. 2	23a. Did tobacc	Month						
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ecto	er (specify)	ırt I. 2		Month o use contribute to	Day Yea					
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23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions co	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ecto	er (specify)	2	1 Yes  4a. Was an autopsy performed'  Yes 2	Month  o use contribute to 2 No 3 Pi  24b. Were al prior to death?	Day Year of the cause of dea robably 4 Aunitory 5 Aunit					
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25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one) 1 Certifying Phyone)	Hospital:  2 Ba. Date of Injury  (Month, Day Year)  4 19 Cape  28e. Place of Injury - At hobuilding, etc. (Specify Local Yesician: To the best of my known	ER/Outpatient 3[ 28b. Time of Injury Medge, death occurrence to the complete the co	ying cause given in Pa  26. Pl  DOA Other: 4  28c. Injury at Work? 1 Yes 2 actory, office	lace of Death Che Nursing Home 28d. C 28f. L C Pork e and place, and dideath occurred at 1	1 Yes  4a. Was an autopsy performed Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Month  o use contribute to 2 No 3 Pi 24b. Were an prior to death? No 16 Yes  6 Nother (Spe jury occurred Si which was and Number or Rate) Indigented to the control of the	Day Year of the cause of dea robably 4 Munk utopsy findings avecompletion of causes 2 No settlem SCEN was facilities and facil					
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 1 6

2004

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32. Registrar's Signature

			State	State of Maryland		rtment of H			ene 1. No. 2001	11506
63	Physici	an	1. Decedent's Name (First, Middle, Last)  ROBER	T RICE HEMP,				2. Date of Death Month	Day Year 7. 2004	3. Time of Death 3:50 P
200	/Medic Examin		4a. Facility Name (If not institution, give so 619 WASHINGTON	reet and number)			Location of Death	AFKID I	4c. County of Dea CARROI	th
***	Funeral Director		Social Security Number     6. Sex	M 2 F 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1 MAY 7	(ear) C	thplace (State or Foreign ountry) RYLAND
	show dall	7	Usual Residence of Decedent	10c. City, 7		cation NSTER				10d. Inside City Limits 1 ☐ Yes 2√ No
	the Marylan 28a-f show notified at	Director	10e. Street and Number	AA 17.	SIMI	10f. Zip Code		10	g. Citizen of What C	ountry?
	h with	ai Di	619 WASHINGTON	RD.		21157	1		USA	
36	be filed within 72 hours after death with the Maryland tial Hygiene. Indoorher than "natural", or items 23a or 28a-f show event, the Medical Examinar must be roblined at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	11	Vas Decedent of H Yes, specify Cuba □ Yes 2XNo	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	in 72 hours n "natural" dedical Ex	Completed b	15. Decedent's Educ (Specify only highest grade	completed)	(Give	ent's Usual Occup kind of work done o OO NOT use retired	during most of work	ring	6b. Kind of Business	·
212	giene.	Com	Elementary/Secondary (0-12) 12	College (1-4or 5+)	5	SUPERVIS			ELEPHON	E CO.
Maryland	2 should be filed and Mental Hygi ie marked other raumatic evant,	To Be (	17. Father's Name (First, Middle, Last) G • EUGE	INE HEMP			18. Mother's Nam	e (First, Middle, M EN R]	aiden Sumame) CE	
Many	s 1 and 2 should f Health and Men item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Type SALLIE A. HEMP	oe, Print) - DAUGHTER					City or Town, State, ISTER • M	
	es 1 and 2 of Health a fitem 27 is r other tra		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of natory or other place			0c. Location - City o	
Baltimore,	Pages ment of h ant: If ite		1 ☒ Burial 2 ☐ Cremation 3 ☐ Ro 1 ☐ Cremation 2 ☐ Other (Specify)	ST.	MARK	S CEMET	ERY 4/2		ETERSVII	
Balt	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service License		2	54 E. M	AIN ST.	, WESTMI		ID. 21157
,	Physician		23a. Part1. Exter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	Do not ente		g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a conseque						3 weeks
\$6 8	#	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to for as a conseque	nos of).					J WEEK Z
Ć.	ate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					(n)
8760	cate be physicia the but	dical								
O. Box 6	death certiff le attending ed for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
s, P	S UT 0	d by Ph	Part II. Other significent conditions con	1		nderlying cause giv	en in Part I.	23e. Did tob	·	to the cause of death?  Probably 4 Unknown
Division of Vital Record	e law has b	ompiete						24a. Was ar autops perform 1 Yes 2	y prior to led? death?	autopsy findings available completion of cause of es 2 No
/ita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth		th (Check only one	9)	
on of \	Phys	tlon: To	27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 E	R/Outpatier 8b. Time of Injury	28c. Injui Wor	y at	ome 5 seside 28d. Describe ho	nce 6 ⊡Other ( <i>Sp</i> w injury occurred	ecify)
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, str			28f. Location (St. City or Town		Rural Route Number,
	To the Hospital or At within 24 hours after or To tha Funeral Dirac completely filled in by	edical C	29a. Certifier (Check only one)  Certifying Physical Exemination (Check only one)	sician: To the best of my knowl ter: On the basis of examinatio and manner stated.	ledge, deatl on and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the ca irred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Sign at re and title of certifier	ATTEN					9d. Date signed (Mo	
•	War 5		With 20		SICIA		1122	P	PRIL 19,	2004
	ر کد حی		30. Name and address of person who co	_		Print)	D WES	MWSZE	e, MD 2	1157
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 0	32. Registrar's Signatu	re H	A.v.				·

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John H. Hast April 8, 2004 1805 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 803 Reserve Champion Drive, #201 Montgomery Rockville 5. Social Security Number 6. Sex 1X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) November 4, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days Hours 220-16-6302 76 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show rel', or Items 23a or 28a-f shov Examirer roust be notified at 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 Reserve Champion Drive, #201 20850 permit. Pages 1 and 2 should be filed within 72 hours after death: Department of Health and Mental Hygiene. Importent: If item 27 is markad other than "naturel", or Items 23a any injury or other traumetic event, It e Madical Examiter mast Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of the Elementary/Secondary (0-12) College (1-4or 5+) Safety Director Interior 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Norman R. Hast W. Waneta Shauwecker ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven L. Hast/ Son 20926 Annrita Avenue, Torrance, California 90503 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 16, 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State D 2004 4 □ Donation 5 🛭 Other (Specify) Entombment Gate of Heaven Cemetery Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01305 Rockville, Inc. 300 West Mon Rockville, Maryland 20850

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privaician Myocardial Infarction acute /Medical Due to (or as a consequence of). **Examiner** Diabetes Mellitus years Sequentially list conditions, if any, leading to immediate cause. Extended to improve that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transi Hypertension years Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No þ Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Rheumatoid Arthritis, Osteoarthritis, Glaucoma 1 ☐ Yes 2 📆 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5ty Residence 6 Other (Specify) Certification: To 1 ▼ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. a Funerel Director: A investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 / Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Druges ( Meconta, Mo D27301 April 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 615 West Montgomery Avenue, Rockville, MD 20850 Douglas R. Shumaker, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 6 2004

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7, 2:55 APRIL 2004 FRANKLIN E. HERMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Yrs 1925 PENNSÝLVANIA 79 Director 193-14-8606 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Show r itema 23a or 28a-f shov-iner count be notified at 1 ☑ Yes 2 ☐ No Directo LEBANON LEBANON PA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 102 E. KLINE STREET 17046 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married ö 1 ☐ Yes 2 🛱 No Specify: \*natural", or WHITE Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical during most of working College (1-4or 5+) than Elementary/Secondary (0-12) STEEL 10 MACHINE OPERATOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be fi f Health and Mental Item 27 is marked o JOHN HERMAN KATHERINE ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is 15217 BAUGHMAN DRIVE, SILVER SPRING, MD 20906 FRANKLIN E. HERMAN, JR., Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) GRAND VIEW MEM. PARK 04/12/2004 ANNVILLE, PENNSYLVANIA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee EDWARD SAGET FINERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER OF LUNG WITH METASTASIS /Medical Due to (or as a consequence of): Examiner MALIGNANT PLEURAL EFFUSION S\_uential\_ list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit RESPIRATORY FAILURE and Due to (or as a consequence of): the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ō in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ∑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 TYes 2 ₩ No 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Hospital: 1 V Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Hospital or Attent within 24 hours after death To the Funeral Director: 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by 4 Homicide 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D47330 APRIL 7, 2004 tho mus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS V. JOSEPH, M.D., 50 W. EDMONSTON DRIVE, ROCKVILLE, MD 20852 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 14 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** <u>April</u> 9, 2004 Edith Hitz 1:10am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F Yrs. **Director** 87 April 15, 1916 Maryland 222-22-5861 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show emportant: if item 27 is marked other then "natural", or items 23s or 28s-f show emportant: it item 27 is marked other than 2000. 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 1 TXYes 2 □ No Maryland Montgomery Gaithersburg Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 309 Russell Avenue 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ High School Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lulu Long Henry Brechbill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5900 Wynnwood Road, Bethesda, MD 20816 Gregory Hitz (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 4/10/04 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Eugeral Service Licenses Gaithersburg, MD 20877

Fart1. Enter he sease, in complications that mused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or beart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years **Physician** Artherosclerotic Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Hypertension Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year detached for 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown ģ 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 8 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Cerebrovascular Accident Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypothyroidism has autopsy performed? page 2 1 Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire Certification: To 1 Yes 2 X No his filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier D 33357 April 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave., Chevy chase, MD 20815 MD Jonathan Musher, Lee 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2004 Docks APR Registrar

Registrar

			For State Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of <i>tificate of</i>	Health an <i>Death</i>	d Mental H	ygiene Reg. No	2004	14511
	Physicia	an	1. Decedent's Name (First, Middle, Last)	_				2. Date of I Month	Da		3. Time of Death
	/Medic	al	EDITH  4a. Facility Name (If not institution, give si	C.		HOLT  4b. City. Town.	or Location of D	Apri]		, 2004 County of Death	4:35 P. M
	Examin	er	5809 84th Avenue				rrollto			Prince G	eorge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days		Ain (Month.)	Dav. Year	9. Birthp Cour	place (State or Foreign
	Director		579–28–1726 Usual Residence of Decedent	M 2 F	81 Yrs.			April	13,19	22 Vir	ginia
	yland yland		10a. State 10b. County		y, Town or Lo	cation				1	Od. Inside City Limits
	Ba-1 s	ctor	Maryland Prince Geo	orge's Ne	w Carro						1 Yes 2 No
	with the or 2	Dire	10e. Street and Number 5809 84th Avenue			10f. Zip Code 2078	4		_	tizen of What Cour	•
	death	Funeral Director		Was Decedent Ever in U.     Armed Forces?	S. 13. V			? (Specify Yes or I uerto Rican, etc.)		14. Race - Americ Black, White,	can Indian,
336	be filed within 72 hours after death with the Maryland ital Hygieno. Id other then *natural', or itama 23a or 28a-f show event, the Mudical Extroiting facet be notified at	þ	1 ☐ Never Ma <i>rr</i> ied 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give X Year or Dates:	1	Yes 2 No		derio riicari, etc.)			hite
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g	e filed with Il Hygiene. other the	e Cc	17. Father's Name (First, Middle, Last)		Z-SCATIL.	IIIISCIAC		Name (First, Midd			
ylar	2 should be and Mental is marked o	To E	John Harvey Sow	der			Mary	Catheri			
Maryland	12 sho h and 7 is m traum	j v	19a. Informant's Name/Relationship (Typ	oe, Print)		•				or Town, State, Zip	111.
Б, _	Healt tem 2 tother	. 19	David N. Holt -son  20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of natory or other pl	1	Date		ocation - City or To	and 21136 own, State
Ē	Pages int: If I		1 Surial 2 Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)					rk 4/15/2	2004	Laurel, 1	Maryland
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic ex		21. Signature of Funeral Service License	Burgarendy	DC 42	Name and Addi	ess of Facility Borgwar er Mill	dt Funer	al Ho	ome, PA.	land 20705
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	Physician		Immediate Cause (Final disease or condition	Metasta							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
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	cuted	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
8760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequ	uence of):						
289		edical	d								
Box	death certific e attending p od for use as	an/M	23b. was decedent pregnant	Bc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnan	ev			23d. Date of delive	*
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<u> </u>	law requires that the de as been signed by the 2 should be detached	y Ph	Part II. Other significant conditions con	tributing to death but not rest	ulting in the ur	iderlying cause g	iven in Part I.	23e. Die	d tobacco	use contribute to th	ne cause of death?
Records,	equires an sign	ed by						_ 1)	Yes 2	□No 3□Prob	ably 4 Unknown
eco	2 2 2	Completed						24a. Wt	opsy	prior to con	psy findings available mpletion of cause of
	T eag							pe 1 ☐ Yes	formed?	death? 1 ☐ Yes	2 No
\ <u>\</u>	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2  No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	3 DOA 0	thor	Death (Check only		6 ☐Other (Specify	w)
Division of Vital	ding Phy h. After this funeral o	P	27. Manner of Death  1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describ			7/
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<u> </u>	in Diff.	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, rarm, stre	eet, ractory, office	•		own, State		ir noble reumber,
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)			David Haidak, M.D	mpleted cause of death (Item ). 7525 Greenw	ay Cen	ter Dr.,	, #215 G	reenbelt	, Mar	yland 20	770
	Sta Registr	_	31. Date filed (Month, Day, Year)  APR 1 6 200	32. Registrar's Signa	ture	Spark	2				

			For State Registrar	State of M	arylan		artmen rtificat			and M		Reg.	- 21	004	1451
/N	sicia ledic amin	al .	Decedent's Name (First, Middle, La Flora F. Hurle     4a. Facility Name (If not institution, giv	Y e street and number)			4b. City,		Location o		2. Date of Month April		Day 5 4c. County		3. Time of Death  10:40 A <sup>M</sup>
Fune Direc			Genesis Eldercar  5. Social Security Number  579–10–0118			nter last binhday) Yrs.	If Under Months		napol If Under a Hours		8. Date of (Month,	Birth Day, Ye 22,		Coun	ace (State or Foreign
Maryland	lied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne A	rundel	10c. City	/, Town or Lo	ocation		Anna	ıpoli	.s			10	0d. Inside City Limits 1 ☆Yes 2 ☐ No
with the	I De Vol	I Director	10e. Street and Number 7 Silverwood Cir	cle #4	-		10f. Zip	Code	214	103		10g.	Citizen of V		try?
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nd 2 showall y	er trauma		19a. Informant's Name/Relationship ( Jacqueline Spel		2		-				al Route Nu #4		-		<sup>Code)</sup> 21403
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permit. Departm Importa	any inju		21. Signatura of Funeral Service Licenter	1500											. Home MD 21401
Physic /Medi Exami	ical ner	ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that cause one cause on each is  a.  Due to (or as  b.  Due to (or as  c.  Due to (or as	ine. s a consequ (	So, uence of): Cho I	er the mod			cardiac o	or respirator	y arrest,			Approximate Interval Between Onset and Death
The law requires that the death certificate be executed.  The law requires that the death certificate be executed to has been signed by the attending physician and	ched for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic pr				2000-200	_	1	te of delive	ry Day Year
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To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After	completely filled in by the t	Certification;	2 Accident investigatio 3 Suicide 6 Could not be determined	e 29a Place of In	iury - At ho tc. (Specif)	ome, farm, st	M reet, factory		/es 2 □ l			n (Street Town, Si		er or Rurai	Route Number,
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To th withir To th	сош	Me	29b. Signature and title certifier 30. Name and address of person with	completed cause of	) death (Item	1 23a) (Type,			371		er, Mi)		Date signed	r	*
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 20, April 2004 10:30 a.m William John Hersman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Lusby

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 2870 Prism Court Calvert Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M M 2 □ F West Virginia 234-74-0018 57 May 18,1946 Director Usual Residence of Decedent with the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or 28a-f show i Health and Menial Hygiene. Item 27 is marked other then "netural", or Items 23s or 28s-1 shov other traumatic event, the Medical Examinal must be notified as 1 ☐ Yes 2@No Directo Lusby Calvert Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2870 Prism Court 20657 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ann of Health and Merial Hygiene.
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1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 No 1☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Pesidenca 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe SAR VO 30. Name and addre's of Jerson who complete case of death (Item 23a) (Type, Tint) M.D., 24035 Three Notch Road, Hollywood, MD 20636 Patrick Jarboe, 32. Registrar's Signature 31. Date filed (Month, Da State 2004 Registrar

		_ For	State of Maryland	l / Depa	artment	of Hea	Ith and M			2001	11.515	
		1 - State Registrar		Ce	rtificate	of De	atn	,	Reg. No.	C 0 0 4	1 14010	-
Physic	160,	Decedent's Name (First, Middle, Last)	)					2. Date of Dea	Day	Year	3. Time of Death	
Physic /Med		Mary Elizal	beth Holl	ey				April	28	2004	- 0000 kg M	_
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or Loc	ation of Death		4c. C	ounty of Death	1	
	٠	Union Memorial I					timore				imore	
Funeral		5. Social Security Number 6. Sec	TM 28 F	st birthday) Yrs.	If Under 1 Months		Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, Da)	y, Year)		hplace (State or Foreign untry)	
Director		216-32-8796 Usual Residence of Decedent	68	113.				May 29,	1935	Mar	yland	_
and w		10a. State 10b. County	10c. City	Town or Lo	cation			-			10d. Inside City Limits	-
sho	5				n. i.						1 ☐ Yes 2 No	
he N	Director	Maryland St. Ma	ary's		Ridg 10f. Zip			1	10a. Citize	en of What Co	untry?	-
with Dead					70.1.2.				TIm d A	ted Sta		
eath	Funeral	17043 St. Peter C	Laver Koad  12. Was Decedent Ever in U.S	S. 13.	Was Decede		680 nic Origin? (S	pecify Yes or No- o Rican, etc.)		1. Race - Ame	rican Indian,	-
ter d	S	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ■ No					o Rican, etc.)		Black, White		
5-UU3b 72 hours after death with the Maryland natural, or items 23a or 28a-1 show	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1□Yes 2	No S	pecify:		S	Specify: B1	.ack	
72 hours		15. Decedent's Edu	cation	16a. Dece	dent's Usual	Occupation	out of war	tina	16b. Kind	of Business/I	industry	_
rin 72	Completed	(Specify only highest grad	Coltege (1-4or 5+)	lite.	DO NOT use	e retired)	g most of wor	KIII G				
ZTZT d within giene. rr then	E	12		Car	e Prov	vider			Cł	nildcar	·e	_
and Z d be filed ental Hygi ced other c event, I	Be	17. Father's Name (First, Middle, Last)				18.	Mother's Nan	ne (First, Middle,	Maiden S	iumame)		
	To	John Wesley Hol	ley					ephine B				_
Mary d 2 shou th and M 7 is mar traumat		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ing Address	(Street and	Number or Ru	ral Route Numbe	er, City or	Town, State, Z	Tip Code)	
- 5 - 0 -		Kevin Lee Graham					ue, Ba	ltimore,				_
of Healt		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	20b. Pl	ace of Disponentery, cre	osition (Nam matory or ot	e of her place)		Date	20c. Loca	ation - City or	Town, State	
MOF Pages nent of int: If it		* 4 □ Donation5 □ Other (Specify)			r Clav		5-1-			e, Mary		
Battimore, permit. Pages 1 a Department of Her Important: If item any injury or othe		21. Signatur of Funeral Service Libens	600	2	2. Name and	d Address of	Facility Br	insfield	Fune	eral Ho	ome, P.A.	
<b>n</b> 88556		1 Way Ki	Z/Z/O M0111							own, MD	20650-0279	
		23a. Part1. Enter the disease, or composhock, or heart failure. List only d	idations that caused the death he cause on each line.	. Do not en	ter the mode	of dying, su	ich as cardiad	or respiratory ar	rrest,		Approximate Interval Between	
Physiciar		Immediate Cause (Final disease or condition	Mult.	SVE	tem	Ox	aan	Faili	LVE	2	Onset and Death	
/Medica		resulting in death)	Due to (or as a consequ	ence of):			9	7 00 1			11	
Examine		Convertigity list conditions	, Sepsi	5							one week	_
7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):	Λ		10		`		1 1.	
cuter	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Commun	TY	HCG	WITE	di	neumi	onio	9	two week	5
60, the executed sician and buriat-transit		resulting in death) Last	Due to (or as a consequ	ence of):	C	3						
376 ate b hysic	Ilcal	•	d									-
I Records, P.O. Box 687. The law requires that the death certificate ste has been signed by the attending prhysicage 2 should be detached for use as the!	Physician/Medi	IF FEMALE:										,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Box eath cert attending for use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	□Ectopic pre				23	3d. Date of deli Month	ivery Day Year	
o deg	SC	1 ☐ Yes 2 A No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5	Other (spe	ecify)						
P.O.	P <sub>y</sub>	Part II. Other significant conditions co	patributing to death but not resu	itting in the I	underwing ca	ause given in	Part I	23e. Did to	obacco us	e contribute to	the cause of death?	-
S res th	b	Pair II, Other significant conditions co	intributing to double but not rose	intering in the c	and only and or	adoo givoii ii		10		-	obably 4 Unknown	
Orc requi	ted									`		_
Rec e law has b	du							24a. Was autop		prior to death?	stopsy findings available comptetion of cause of	
The cate h	Completed							1 ☐ Yes	2 No	1 ☐ Yes	2ENO	_
/ita	Be	25. Was case referred to medical examiner?	Hospital > 6			Other		ath (Check only o				_
of \	2	1 Yes 2 No		ER/Outpatie			4 Nursing H	lome 5 Resid			cify)	_
ing P	on:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M Z	8c. Injury at Work?	2 🗆 No	28d. Describe I	now inquiy	Occarred		
Vision of Vital Attending Physicien: or death. ector: After this certifical by the funeral director, it	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	mo form s			2 🗆 140	28f Location (	Street and	Number or Ru	ural Route Number,	_
Division of Vital Records, for Attending Physicien: In Attending Physicien: The law requires: after death.  Director: Atten this certificate has been signe in by the funeral director, page 2 should be e	Certification:	4 Homicide determined	building, etc. (Specify	) (alim, s	ireet, factory	, once		City or To				
Hospital 94 hours a Funeral I		29a. Certifier Certifying Phy	ysician: To the best of my know	wledne dea	th occurred	at the time.	tate and place	and due to the	cause(s) a	and manner as	s stated.	
Division of Vital Re To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha compleiely filled in by the funeral director, page	edical	(Check only 2 Medical Exam	iner: On the basis of examinat	ion and/or	nvestigation,	in my opinio	on, death occi	irred at the time,	date and p	place, and due	to the cause(s)	
To the within 2 To the complei	Me	29b. Signature and title of contribut			290	. License nu	mber	1	29d. Date	signed (Monti	h, Day, Year)	
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7/3		Chelina Va	enses mD	30	1 Eas	+ Lani	Wersit	y far Yn	ay	Balto	mb 2895	
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Regis		apk 3	2004	Be	Boon	130						

			1 - For State Registrar			of Marylar				ealth a Death	and M		Reg. No.		04	145	116
	Physici	an	Decedent's Name (First, M									2. Date of De	ath Day 12	200	ear	3. Time of De	
	/Medic	cal			Hacke			45 035	Tour	Location of	of Dooth	APLII		County of		2:00	F"
	Examin	ner	4a. Facility Name (If not instite  Manor Care					46. City	Lar		or Death					eorge':	c
-	Euperal		5. Social Security Number	6. Se		7. Age (In yrs.	last birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Bir			. Birthpi	ace (State or F	
	Funeral Director		219-20-6433	10	]M 2□ <b>X</b> F	89	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept.	25,1	914	Coun M I	500	
	pu ,		Usual Residence of Deceden	nh/		10c Ci	ty, Town or Lo	nation							11	od. Inside City I	Limits
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	a or		2301 Calve	rton	Δνρ			101.2		21216	ń			USA		.,,	
	ms 23	Funerai	11. Marital Status		12. Was Dec	edent Ever in U	I.S. 13.	Was Dece				city Yes or No Rican, etc.)	-	14. Race -			
٥	or ite		1 Never Married 2 1	Married	Armed Fi 1 ☐ Yes If Yes, Gi	27 No		ir Yes, spo 1 ☐ Yes		n, мөхісап Specify:	i, Puerto	Hican, etc.)		Black, Specify:			
3	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than "natural", or items after the recitied at	d by	3 X Widowed 4 □ Divor	ced	Year or C	ates:									B1a		
9500-61212	natu	Completed	15. Dece (Specify only hi	dent's Edu hest grad	ication le <i>completed)</i>		16a. Dece (Give	dent's Usi	al Occupa	ation <i>furing</i> most )	t of worki	ng	16b. Ki	nd of Busir	ness/Inc	lustry	
7	within ane. than	m	Elementary/Secondary (0-1	2)	College (	1-4or 5+)				, perat			Г	ept.	St	ore	
	il Hygie other	ပိ	17. Father's Name (First, Mid									(First, Middle,					
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a Z	2 should and Men is marks aumatic		19a. Informant's Name/Relat	onship (T	rpe, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	r or Rura	l Route Numb	er, City o	r Town, Sta	te, Zip	Code) 20	744
	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		Elsie Parke	r /	niece							-				on, MD	•
<u>o</u>	00		20a. Method of Disposition  1 Burial 2 **Cremati	on 3 □F	Removal from	State	Place of Dispo cemetery, crea					ate		cation - Cit			
Ē	Pages tment of tant: if it ijury or o	1 3	`4 □Donation 5 □Othe	(Specify)		Me										a, VA.	
Baltimore,	permit. Pag Department Important: f any injury o		21. Signature of Funeral Sen	ice Lio	)	00						all Fu				0715	
	20240		23a, Part1, Enter the disease	or comp	lications that	caused the dea						y . Bo		, MD		Approximate	
			shock, or heart failure. Immediate Cause (Final	List only o	ne cause on	each line.						. ,				Onset and Dea	an ath
	Physician /Medical		disease or condition resulting in death)	-	a	cinom (or as a consec		Jvar	у		-				-	years	
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	and trans	Examiner	that initiated events resulting in death) Last		C. Due te	/22.22.2.2.22.22	wassa of										
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	death certificat e attending phy od for use as the	Physician/Med	IF FEMALE: 23b. Was decedent preggant			tcome of pregn								23d. Date o	f delive	ry	
ROX	death e attel d for i	iciai	in the past 12 morms? 1 ☐ Yes 2 ☑ No		4□Preg	birth 2 ☐ Feta nant at time of o		JEctopic ; ∃Other (s	pecify)					Month		Day Yea	ır
л О	by the	hys	9 Unknown	-	9□Unkr	iown											
	requires that the de been signed by the a hould be detached f	by	Part II. Other significant con		ntributing to o	leath but not res	sulting in the u	nderlying	cause give	an in Part I.						e cause of deal	
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	: The law icate has r, page 2											1 ☐ Yes	2 <b>N</b> O			2□ No	
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to med examiner?  1 ☐ Yes 2 ☑ No		Hospital:	Innationt OF	ER/Outpatier	• • • • •	Othe	nr 1	-	(Check only o		E Mother	Cnach	.1	
o	Phy or this oral d	I ⊢ .	1 Yes 2 No		28a. Date	of Injury	28b. Time o		28c. Injury	at		ne 5 Resident			эрөспу	)	
<u>o</u>	Attending F r death. ector: After by the funeri	ation	1 Matural 5 ☐ Pe 2 ☐ Accident inv	nding estigation	(Mor	nth, Day Year)	Injury	м	Work	<br Yes 2 □!	No						
DIVISION	4 2 0 5	Certification:		uld not be ermined	28e. Place	of Injury - At h	iome, farm, sti	reet, facto	ry, office		1	28f. Location (3			or Rura	Route Number	r,
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	ne Hospital or At 24 hours after of ne Funaral Direct detely filled in by	Medical	(Check only 2 Med		ner: On the b	e best of my knowasis of examina											
	# 등 # 등	Med	one) 29b. Signature and title of cel	tifier	and mar	iner stated.		29	ç. License	number			29d. Dat	e signed (A	Aonth, L	Day, Year)	
,	or with		1 Am	0	1.6	win	160			13.	52					2004	
V	(2)		30. Name and address of per	son who c	ompleted cau	se of death (Ite	m 23a) (Type.			-			πрі		,	2004	
1			Paul A. De		, M.D	. 420	3 Que	ensb	ury	Rd.	Ну	attsvi	i11e	, MD	•		
	Sta		31. Date filed (Month, Day, Y	004	32. F	Registrar's Sign	ature	U									
	Registr	rar	APR 167	TUU	ALC: UNIVERSE		P										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. cmState of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** EDWIN IVAN HERNANDEZ РΜ April 2004 7:24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Jniversity Boulevard and Adelphi Road College Park Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 22, 1987 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 □ F Months Days Hours D. C. 577-17-6087 16 Aug. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Md. Prince Georges Hyattsville 1√E Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6643 23rd Avenue 20782 U. S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2□ No Specify: Salvadoran Specify: Hispanic 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry . Hygiene. School Elementary/Secondary (0-12) College (1-4or 5+) Student 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F is marked of eq pinous Jose Santos Hernandez Norma Velasquez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Santos Hernandez (Father) 6643 23rd Ave., Hyattsville, Md. 20782 Health am 27 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ₽ 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit, Page Department of Important: If `4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 04-23-04 Silver Spring, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, DC 20010 Wanda Dacon, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached the à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ pe 1 ☐ Yes 2 🕦 o 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Ses 2 □ No 24a. Was an has page certificate 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1∡ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at scene 2 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Deiver Certification: or Attanding 715P Natural CAR INVOLVED IN NOTOR 5 Pending 2 Accident 4/15/ 04 death investigation after death VEHILLE COLLISION 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) UNIVERSITY BLVD AND ADKLOHI PLDY CULKER P.M.K., M. filled in by 4 Homicide DADWA 24 hours a Funeral ( 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manney stated. completely (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and .0 O.C.M.E. April 16, 2004 DA RIAREFOR 30. Name and ad cause of death (Item 23a) (Type, Print) ss of person who 111 Penn Street, Baltimore, Maryland 21201 TEDKING 31. Date filed (Month, Day, Year) State APR 2 0 2004

Registrar DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 11 1 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) .Physician Garv Allen Holland 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street and number) Examiner Stella Maris Hospice Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 27, 1965 9. Birthplace (State or Foreign 5. Sociel Security Number 7. Age (In yrs. last birthday) Country) Maryland **Funeral** 1 M 2 □ F 38 213-86-5524 Vrs Director Usual Residence of Decedent e filed within 72 hours after deeth with the Marylend bl Hygiene.
other than "naturel", or flems 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Locetion 10a. State traumatic event, the Medical Examiner must be notified at 1 to Yes 2 □ No Hyattsville Director Maryland Prince George's 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 20782 U.S.A. 5719 43rd Avenue, Apt. 1 Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: Baltimore, Maryland 21215-0020 Completed by White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Construction Electrician Spartan Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill and Mentel H is marked off Parkes Elizabeth Holland David Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 sh Department of Health and Important: If itam 27 is m 5719 43rd Avenue, Apt. 1, Hyattsville, MD Elizabeth R. Holland - Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State ò 04/22/04 Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Injury 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21. Signatury of Funeral Service Lilensee any ir 23a. Fart : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 1,0blastona Examile, a Due to (or as a consequence of Examiner Hospital or Attanding Physician: The law requiras thet the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed TLIYES 2K NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification: To 1 ☐ Yes 2 No his 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 5 Pending 1 XNaturat 2 ☐ Accident 1 ☐ Yes 2 ☐ No investigation death. Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) fillad in by 4 Homicide To the Hospital
within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2007 410854 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) PL. Baltimore md. ST. Risebero 301 PAUL 31. Date filed (Month, Day, Year) State APR 2 0 2004 Registrar

**DHMH 16 Rev 6/95** 

		1 - For State Registrar			•	artment o <i>rtificate</i>	of Dea	th		Reg. No	2004	1451
hysicia	an	Decedent's Name (First, Middle, La     DANGY, HER				,		, .	2. Date of D			3. Time of Deat
Medic	al	DANCY HER	RRING	-1					APR	17	2004	1:54 P
xamin	er	NATIONAL NAVAL				4b. City, To	wn, or Locati ETHESD			4C.	MONTGOI	
eral		5. Social Security Number 6. S	Sex 7. /	Age (In yrs. la	st birthday)	If Under 1 Y		der 24 Hrs.	8. Date of Bi	rth		MERI oplece (State or For untry)
tor		240-38-7267 Usuel Residence of Decedent	M 20F	7.6	Yrs.	MOTALIS D	4,5		Apr. 9	, 1	928 CĬ	inton, N
		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Lin
	ctor	N. C: Cumberl	and	Fay	ettev	ille.						1 <b>∑</b> Yes 2 □
	Dire	10e. Street and Number				10f. Zip Co	ode				zen of What Co	•
	Funeral Director	810 Executive  11. Marital Status	12. Was Deceder	nt Ever in U.S.	. 13. V	Was Deceden	283(	)5 Origin? (Spi	ecify Yes or No Ricen, etc.)	Uni	ted St	
	Fun	1 Never Married 2 Married	Armed Forces 1 Yes 2 I		}	Yes, specify	,		Ricen, etc.)		Black, White	
	Completed by	<b>¾</b> Widowed 4 □ Divorced	Year or Dates	s:		/1		:п <b>у</b> :				n India
	olete	15. Decedent's Ed (Specify only highest gra	ide completed)		(Give	lent's Usual O kind of work o DO NOT use n	one durina r	nost of work	ing	16b. Ki	nd of Business/I	ndustry
	om	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Bri	ick Ma	son			Co	nstruc	tion
	Be	17. Father's Name (First, Middle, Last,					18. Me	other's Name	(First, Middle			
	၉	Gethro Herring			400 14 10		Do	osha_	Jacob			
1		19a. Informant's Name/Relationship (									r Town, State, Z	
OCISE CONTROL OF SELECTION OF THE PROPERTY OF		Catherine M. Si 20a. Method of Disposition		200. Pia	ICE OF DISDO	L REGE sition (Name of natory or other	27	KWY.	Fores	20c. Lo	Lile, Md cation - City or 1	20747 Town, State
SOCE.		1 □ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		6		•		y 4-	24-04	Sno	w Hill	N.C.
ouce.		21. Signature of Funeral Service Licer	1See (		22	. Name and A	ddress of Fa				ary P.	
a	-	220 Part Solveth Commence		- 4 46 - 4 - 46				akes	Pl. Mi	tch	ellvil	le,Md.
	174	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final						as cardiac o	or respiratory a	rrest.		Approximate Interval Between Onset and Death
an cal		disease or condition resulting in death)		METAST is a conseque		LYMPHO	MA					
er		Socreptiothe list and disease	b		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	is a conseque	ince ol):							
	Examiner	Cause (Cisease or injury that initiated events resulting in death) Last	c. Due to (or a	s a conseque	ince of);							
ייי ביש מש ווופ בישומי- וישומי	calE		d									
	Med	IF FEMALE:						-151				
	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetel d	leath 3 🗌	Ectopic pregn				2	3d. Date of deliving	ery . Day Year
	yslo	1 Yes 2 No 9 Unknown	4□Pregnant 9□Unknown	at time of dea	ıtn 5⊔	Other (specify	y)					
	by P	Part II. Other significant conditions of	ontributing to death	but not result	ing in the un	derlying cause	given in Pa	rt I.	23e. Did t	obacco u	se contribute to	the cause of death?
	ted		<del></del>						10	Yes 2∑	DNo 3□Pro	bably 4 DUnkno
l .	Completed								24a. Was		prior to co	opsy findings availa
									perfo	rmed? 2 XNo	death? 1 ☐ Yes	2 🗆 No
	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ YNo	Hospital:	tient 2 EF	P/Outpationt	20004	04		(Check only o		Other (Speci	
		27. Manner of Death	28a. Date of In (Month, D	iury 2	8b. Time of Injury		Injury at Work?		ne 5 ⊔ Hesi 28d. Describe i			Ty)
במונילופופול ווופס ווי כל אום ומופימו מופינמוי לשמפ	atlo	1 Natural 5 Pending 2 Accident investigation	1	ay reary	mjury		vvdik? 1 ☐ Yes 2	□No				
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	280. Place of Ir	njury - At hom etc. (Specify)	e, farm, stre	et, factory, off	ice	4	28f. Location (3 City or Tov	Street and vn, State)	Number or Run	al Route Number,
		29a. Certifier 1 \(\nabla\) Certifying Ph	ysician: To the bes	t of my knowle	edge death	occurred at th	e time, date	and place is	and due to the	221122(2)	and manner as a	tata d
	Medical	(Check only 2 Medical Exam	niner: On the basis and manner s	of examinatio	n and/or inv	estigation, in r	ny opinion, o	leath occurre	ed at the time,	date and	place, and due t	o the cause(s)
	ž	29b. Signature and title of certifier	Λ. 4			29c. Lic	ense numbe	er		29d. Date	signed (Month,	Day, Year)
		1 yours	- Nanh	Longs		010	123317	'0 (VA	)	Apr	19,20	504
		30. Name and address of person who			(Type, F	Print)		NATI		VAL	MEDICAL	CENTER
		JANINE R. DANKO 31. Date filed (Month, Day, Year)	LT MC	USN trar's Signatur				DETH	FONY WI	7 208	89-5600	
Stat	ρ.	JI. Date med (month, Day, Today	Ja. Megis	liai a dignatui								

ORIGINAL

			1 - For Stete Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of He tificate of D	ealth and M Death		giene 2 () Reg. No.	104 14521
	Physici /Medio		1. Decedent's Name (First, Middle, Last Mamie Reather H.					2. Date of De	ath Day 2	Year S137pM
	Examir	er	4a. Fecility Name (If not institution, give Pineview Nursin			4b. City, Town, or Clinton			4c. County Prin	ice George
	Funeral Director		5. Social Security Number 6. Se 1 C C C C C C C C C C C C C C C C C C	7. Age (In yrs. 93	(ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Dec. 5	y, Yeer)	9. Birthplace (State or Foreigr Country) N. Carolina
	Maryland e-f show	tor	10a. State 10b. County  MD Prince G		y, Town or Lo					10d. Inside City Limits 1    Yes 2   No
	th with the 23a or 28 unt be not	ral Director	10e. Street and Number 13601 South Hil	l Rd.		10f. Zip Code 20613			10g. Citizen of V USA	What Country?
036	urs after dea al', or items	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cuban I □ Yes 2 XNo	panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Rad Blad Specify	ee - American Indian, ck, White, etc. Y: Black
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show say injury or other traumatic event, the Mudical Examiner risal by nutilisal at ODGe.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occupat kind of work done di DO NOT use retired) SE Wife	tion uring most of work	ring	16b. Kind of Bi	usiness/Industry
<b>Maryland</b>	uld be filec Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) Barry Smith				18. Mother's Nam Lena Sr		Maiden Suman	ne)
	and 2 sho Baith and I n 27 is ma		19a. Informant's Name/Relationship (Ty Walter Harvey/C	aregiver	470	g Address <i>(Street ar</i> L Maui St	, Clinton	n, MD 20		State, Zip Code)
Baltimore,	. Pages 1 Iment of He tant: If iter jury or oth		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State Asbi	iry Un	sition (Name of natory or other place) Lted Cem.	4/17,		Brandy	wine, MD
Ball	Departiment Important in Superior Super		21. Signal ure /1 Funeral Service Li en/	wellen		5500 Aller	ntown Rd	Camp S	prings,	l Services MD 20748
68760,	Physician /Medical Examiner and physician and physician and physician and physician and physician sit is the physician and physi	al Examiner	23a. Pakt. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	Substitution of the substi	CAN				Approximate Interval Between Onset and Peath
.O. Box	The law requires that the death certificate ate has been signed by the attending phy. age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetel 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Dat	te of delivery nth Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not resu	Ilting in the un	derlying cause giver	n in Part I.	23e. Did to		nbute to the cause of death?  3 Probably 4 Unknown
al Records,	ician: The law re certificate has bee rector, page 2 sho	Completed						24a. Was autop perfor	sy promed? c	Nere autopsy findings available orior to completion of cause of death?  Yes 2 No
Division of Vital	d is	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	lospital: 1 Inpatient 2 I	ER/Outpatient 28b. Time of Injury	28c. Injury a Work?	at	me 5 Resid	-	
Divis	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	)			City or Tow	m, State)	er or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Physical Examination (Check only one)  2 Medical Examination (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	viedge, death ion and/or inv	estigation, in my opin	nion, death occur	ed at the time, o	date and place, a	and due to the cause(s)
	F 1 1 8		MO	m		D-18	545	A	PRIL	16, 2004
	(3)		31. Date filed (Month, Day, Year)	mpleted cause of death (Item  2010  32. Registrar's Signal	0 04	LINE	CENTE	_ WA	WOOF,	Md. 20602
	Sta Registr	-	APR 1 9 2004	Breeze &	Break	2				

Enoch A. Hannon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #23a per me G832 6/11/04 tas
State of Maryland / Department of Health and Mental Hygiene 2 1 1- State upper item#23a,27,28a-f,PFR MF,C831 5/13/0462 of Death

Reg. No.

Reg. No. 04-02744 cm1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vasi **Physician** Enoch Hannon РМ April 2:00 2004 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 □ F Months Hours 71 246-52-8482 1932 Greenville, Director Nov. 11, Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Prince George Maryland Largo the 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 10151 Campus Way South 20774 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after XYes 2□No 1950 -1 ☐ Never Married 2 ☑ Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1953 natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiens important: if item 27 is marked other that any injury or other traumatic event, If a sonce. Auto Salesman 12th Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Alma Harrington ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10151 Campus Way South; Largo, MD. Cheyenne Hannon/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Oak Hill Burial Park May 1, 2004 Lakeland, Florida 21. Signature of Funeral Service Licensee Tope Funeral Homes 5538 Marlboro Pike 22. Name and Address of Facility wa Forestville, MD. 23a. Part1. Enter the disease, or complications that caused the period by shock, or heart failure. List only one cause on each line shock, or heart failure. List only one cause on each line shock or heart failure. List only one cause on each line shock or heart failure. List only one cause on each line shock or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Thoracic Injuries /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of : Examiner burial-transit attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2□ No TX Yes 25. Was case referred to medical examiner?

11 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 4/21/04 subject was driving and struck a 2:00 p м 2 No death. 1 Yes fixed object 28f. Location (Street and Number or Rural Route Number, 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 44th St. & Sheriff Rd, N.E., 5 roadway 24 hours a LOCKINGY

Washington, DC

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

within 2 To the

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD ARA 31. Date filed (Month, Day, Year) APR 2 7 2004

and manner stated.



111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

April 22, 2004

29c. License number

O.C.M.E.

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State	tate of Maryland / Department		nd Mental Hyg	_	11.523
			Registrar  1. Decedent's Name (First, Middle, Last)	Oe	runcate or Death	2. Date of Deat Month		3. Time of Death
	Physici /Medic		JOSEPHINE ANN I	HALEY		APRIL	18, 2004	
	Examir	er	4a. Fecility Name (If not institution, give street		4b. City, Town, or Location of	Death	4c. County of Deet	
			Chesapeake Wood  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Cambridge If Under 1 Year   If Under 2	4 Hrs. 8. Date of Birth Min. (Month, Day,	Dorches	ter hplace (State or Foreign untry)
	Funeral Director			2XX F 63 Yrs.	Months Days Hours	Jan 18	1941 Mi	chigan
	ehow	7	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2X No
	28s-1	ect	MD Cecil  10e. Street and Number	North	10f. Zip Code	11	0g. Citizen of What Co	untry?
	3a or	Ö	22 Crows Foot D	r.	21901		U.S.A.	-
	deeth	nera	11. Marital Status	Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	14. Race - Ame Black, White	
920	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "naturel", or items 23e or 28e-f ehow other traumatic event, the Medical Exertise must be redified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🗷 Widowed 4 ☐ Divorced	I ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	, dono i mazin, oto.,	Specify:	White
21215-0036	a filed within 72 hours il Hygiene. other than "naturel", vent, Ire Medical Exe	pleted	15. Decedent's Educati (Specify only highest grade co	(Give	dent's Usual Occupation kind of work done during most DO NOT use retired)		16b. Kind of Business/	Industry
213	giene giene er tha	Com	1.2		Homemaker		Own H	ome
ם	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)			's Name (First, Middle, M		
yla	2 should be to and Mental I le marked of raumatic eve	2	Charles Herd			rice Mers		T 0 (1)
Maryland	h and h and 7 le m		19a. Informant's Name/Relationship (Type,		ng Address (Street and Number			
ē,	Peges 1 and 2 ment of Health ant: If item 27   jury or other tra		Margaret DeAnge: 20a. Method of Disposition	20b. Place of Dispo	Crows Foot I	Date North	I East M 20c. Location · City or	D. 21901 Town, State
DE L			1 ☐ Burial 2 【Cremation 3 ☐ Rem *4 ☐ Donation 5 ☐ Other (Specify)	oval from State	matory or other place) Temation 4	1/19/04	CHILDRA	r.p
Baltimore,	permit. Pege Department of Important: If eny injury or once.		21. Signature of Fynerick Save Literature	) G	2. Name and Address of Facility alena Funera	1 Home of		L. Schaech
	Se Production		23a Part1 Enter the disease, or complicat	ions that caused the death. Do not en	18 West Cross ter the mode of dying, such as c	ardiac or respiratory arre	est,	21635 Approximate
			shock, or heart failure. List only one of Immediate Cause (Final	Atherosclerotic	C. divilia	10 Dec	. = -	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Die to (or as a consequence of):	- (A MIOUAS	CUAI DISE	ASE	years.
	Examiner		Conventially list annulitions	Die to (or as a consequence of):  Hy De (teus ic	$\sim$			46415
	₽ #	iner	Sequentially list conditions, if any, leading to instrudiate cause. Enter Underlying Cause (Disease or injury	Due to o as a consequence of):				
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
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687	physicate physicate		d					
ox e	death certificate attending physi	/Me	IF FEMALE: 23c.	If yes, outcome of pregnancy	-		23d. Date of del	ivery
m	0 0 0	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		Month	Day Year
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ds,	uires tha signed kd be det	d by	Appendicitis	Emphesema	GASHIOESON	Ohnson Do	es 2 No 3 Pr	obably 4 Unknown
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Vital	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical		26. Plage	of Death (Check only on	θ)	
of	Physi this c al dire	5	1 ☐ Yes 2 XOIo	1 Inpatient 2 EN/Outpatie		sing Home 5 Reside		cify)
nc	ding F h. After funer	ion	1 atural 5 Pending	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	of 28c, Injury at Work?  M 1 □ Yes 2 □ N		w injury occurred	
Division	Attending or death.	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st		28f. Location (St.	reet and Number or Ru	ıral Route Number,
Ö	tel or A	Certification:	4 Homicide	building, etc. (Specify)		City or Town	, State)	
	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai		an: To the best of my knowledge, dea: On the basis of examination and/or in and manner stated.				
	To the to the comp	Σ	29b. Signature and tyle of certifier	Jan Dio.	29c. License number  4446		9d. Date signed (Month	h, Dey, Year)
				eleted cause of death (Item 23a) (Type)	H446 ST CAN		1/11/07	
_			. / /2 41 . 20/		ST CAL	ubridge M	D 210	613
	Sta Regist		31. Date field (Month, Day, Year) APR 2 2	32. Registry's Signature	Sports	V		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item/205 per State of Maryland / Department of Health and Mental Hygiene 2004 State Registrar AACo. Health Dept. BEM Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 12:15 PM 2004 James 10 uton 4050 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimere
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. of Maryland Medical Mivers, Ly of 5. Social Security Number Center 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 29 1. 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 **∑**M 2 ☐ F 212-54-7595 52 Yrs. 1951 Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a State or than "natural", or itama 23a or 28a-f shov the Medical Examinat must be notified at 1 X Yes 2 □ No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 USA 1370 Tyler Ave death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coca Cola Elementary/Secondary (0-12) 12th College (1-4or 5+) Fork Lift Operator Bottling Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Simms Neal James Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth W. James(Mother) 1370 Tyler Ave Annapolis, Md. 21403 20b. Place of Disposition (Name of Harriery Stress to other place)

Cemetery Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If ite any Injury or ot ance. 1 XBurial 2 Cremation 3 Removal from State Annapolis, Md. \* 4 ☐Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Wm. Reese & Sons Mortuary, 21. Signature of Funeral Service Licensee Larry 1, Seese MOG 483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEDSIS /Medical Due to (or a a consequence of): Examiner cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 ☐ Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 2 0 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No certificate 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17652 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Batto. Md. 2/10/ 215. Lerana 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004

DHMH 17 Rev 1/2001

Registrar

			1 = For Amend Item 3 17, Registrar	State of A	4anılan	91 <b>7729</b> 0 Ce	rtificat	t of H e of L	lealth a Death	and M		jiene eg. No. 2	004	14525
	Dhysisi	22	1. Decedent's Name (First, Middle, Last,	)							2. Date of Deal	th Day	Year	3. Time of Death
类	Physici /Medic		LEELAMMA JACKS	ON							April	15'	2004	11:22A M
	Examir	ıer	4a. Facility Name (If not institution, give	street and numbe	or)		,		Location of	of Death		4c. Count		
	in makari	-83	Washington Adven						Park				tgome	
ě	Funeral Director		5. Social Security Number 6. Security Number 215-66-6489	M 250 F	Age (In yrs. 52	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birth (Month, Day, May 21,	Year)	9. Birthp Cour Ind	place (State or Foreign htry) lia
	land bw		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Mary f sh	to	Maryland Montgomer	rv	Tal	coma Pa	ark							1⊠Yes 2□No
	28a	Director	10e. Street and Number	<del>-</del>			10f. Zip	Code			1	0g. Citizen of	What Cour	ntry?
	3a o	Ö	7801 Wildwood Dri	ve			20	912				India		
	death	Funerai	11. Marital Status	12. Was Deceder			Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No-		ce - Americ	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene.  d other than "natural", or Itams 23a or 28a-f show event, The Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 ☐ Yes 2  If Yes, Give Year or Dates	₫ No	i	irres, spec 1 ☐ Yes 2			і, Риело	Rican, etc.)	1	ck, White, y: Asi	
O	2 ho	Completed	15. Decedent's Edu				dent's Usua					16b. Kind of B	usiness/Ind	dustry
215	e. Bu "r	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of wor DO NOT us	se retired	uring most )	r or work	ng			
	filed withi Hygiene. other than	Con		2 Years		Medi	cal S	urgi			nician			Services
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yla	Men Men arke	2	Abel Jackson	Abel Jose	eph .				Dais	sy 1	Luke			
lar	2 sh and is m		19a. Informant's Name/Relationship (Ty	,	Law	1					il Route Number			111
2	and ealth m 27 her t		Palkulam J. Samuel	L/Brothe:					Driv	100	akoma Pa			
Ore	T it it		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F	lemoval from Stat		lace of Dispo emetery, cren	natory or o	ne of ther plac	θ) 0	4/18	/2004	20c. Location		
Ë	tant:		*4 □ Donation 5 □ Other (Specify)		Geo	rge Wa				_		delphi	, Mar	yland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic once.		21. Signature of Funeral Service License	Percent	~						AL HOME, Avenue,		r Spr	20904 ing, MD
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	ications that caus	ed the death line.	n. Do not ent	er the mode	e of dying	g, such as	cardiac c	r respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pali	mah	ary	Simi	اهم	Sugar					Onset and Death
	/Medical		resutting in death)	Due to (or a	s a consequ	uence of):			() ()	-				
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87	phys the	dicai		1										
9 X	death certificate be executed e attending physician and yd for use as the burial-transit	Physician/Me	IF FEMALE:	3c. If yes, outcom	ne of pregna	ncv						20 1 10		
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of Vital Record	w requir been s should	Completed									24a. Was ar	24h	Were autor	osy findings available
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ā	s afte	Certification;	4 [] Hornicide	building,	etc. (Specify	′)					City or Town	, State)		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	edical (	29a. Certifier 1X Certifying Physical Check only 2 Medical Examination	sician: To the besiner: On the basis and manner:	of examinat	wiedge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ca ed at the time, da	use(s) and ma ite and place,	anner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certiling	200		•	29c.	License	number		29	d. Date signe	d (Month, L	Day, Year)
			<b>→ ∧ ∧</b>	M	_in	<b>v</b> )		370	360			ADTIC	. 15	, 2004
	3		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type.	Print)		-					,
)			Sung Lee, M.D.,					a Par	rk, Ma	ary1	and 2091	. 2		
	Sta Registr		31. Date filed (Month, Day 1 ear) 200	4 32. Régis	strar's Signat	ture &	Spo	uns.	,					

		1. Decedent's Name (First, Middle, La	ist)						2. Date of Month		ay Yea		of Death
ysicia Aedic		Lettie C. James	3						April	18	, 2004	6:20	P 1
amin		4a. Facility Name (If not institution, given		1				Location of (	Death		c. County of De		
		Holy Cross Hosp  5. Social Security Number 6.5		//	1 1-2-b		ver S	Spring	Hrs.   0 Date of		Montgom		
eral ctor		578-24-6907	1□M 21 F		84 Yrs.	Months			Min. April	Day Year	1919 N	inthplace (State Country) Iorth Ca	roli
	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside (	City Limit
a per	ō	D.C. N/A			shingt								s 2□N
age.	rec	10e. Street and Number			20112116	10f. Zij	p Code			10g. C	itizen of What (	Country?	
ad Is	a O	1527 Downing Str	ceet, N.E.				20018	3		Uni	ted Sta	tes	
NE CO	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U	.S. 13. Y	Was Dece	dent of Hi	spanic Origin	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - An Black, Wi	nerican Indian,	
any injury or other traumatic event, the Madical Examinet must be notified at since.	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:			1 □ Yes		Specify:				Americ	an
calE	ted	15. Decedent's E	ducation		16a. Deced	dent's Usu	al Occupa	ation	f		Kind of Busines	s/Industry	
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eve	Be	17. Father's Name (First, Middle, Last	")						Name (First, Mide	dle, Maidei	n Sumame)		
natic	٤	John S. Martin  19a. Informant's Name/Relationship	Tuno Brint)		10h Madie	a Address	- (Ctroot o		y Epps	0:	T C4-4-	The Control	
r traur		Karen A. James P.	,,	ughte					o <i>r Rural R</i> oute <i>Nur</i> N.W., Was				11
other tra		20a. Method of Disposition		20b. F	Place of Dispo cemetery, cren	sition (Na	me of	) (e	Date	20c. L	ocation - City o	or Town, State	
Iry or		1 ☐ YBunal 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci			ncoln M				/24/04	Sui	tland,	Marylan	ıd
y inju		21. Signature of Funeral Service Lice	nsee		22	. Name a	nd Addres	s of Facility	McGuire I	uner	al Serv	ice	
₹ <b>8</b>		Keehad Thomp	20 11		7	7400	Georg	gia Av	e. N.W.,	Wash:	ington,	D.C. 2	.001
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cause one cause on each l	d the deat ine.	h. Do not ent	er the mod	de of dying	g, such as ca	rdiac or respiratory	arrest,		Approxima Interval Be	neewte
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	ical	(	d										
as the	Jedi	IE ECHALE.											
TOT USE as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic p	regnancy				23d. Date of d		Waar
2	sici	1 Yes 2 No	4☐Pregnant a 9☐Unknown	t time of d	eath 5□	Other (s	oecify)			-	Month	Day	Year
Dela 2		Part II. Other significant conditions	contabuting to death I	out not res	ulting in the u	odorhina i	nausa awa	n in Part I	230 Di	d tobacco	use contribute	to the cause of	death?
n n	by	Urinary tract i		2011101103	aiting in the di	idenying (	Jause give	HI II F CALL 1.				Probably 4	_
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page 2 should be detached	Completed	Hypertension							24a. Wi	topsy	prior to	autopsy findings completion of o	cause of
or. pa	င်	Sacral Decubitu 25. Was case referred to medical	S					OC Place of			1 □ Ye	s 2 No	
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ne tur	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		y roar,	rijury	М		es 2 □ No					
n by n	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		jury - At ho tc. <i>(Specif</i>	ome, farm, str	eet, factor	y, office			n (Street al Town, State		Rural Route Nur	nber,
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alduc	Med	29b. Signature and tale of certifier	and mariner s	ated.		29	c. License	number		29d. Da	ite signed (Mor	nth, Day, Year)	
ŏ			Mr.				D 323	332			il 20,		
		1 187 57	NVL							P1.	,		
		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type	Print)							

			1 - For State Registrar	State	of Maryla		artmen <i>rtificat</i>			ind Me			2001	A	527
			1. Decedent's Name (First, Middle	, Last)				-			2. Date of Dea	ıth		3. Time o	of Death
	Physici /Medi		Elizabeth Garv	er Jolie							Month April	15,	2004 Year		.5P <sup>M</sup>
	Examir		4a. Facility Name (If not institution	give street and n	umber)		4b. City,	Town, or	Location of	f Death		$\overline{}$	. County of De		
			6777 Surreywoo				Bet	thes	da			M	ontgome	ry	
н	Funeral		5. Social Security Number 271–28–0530	6. Sex 1 ☐ M 2 🛣 F		s. last birthday) O Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	, Year,	9. B	rthplace (State country)	or Foreign
	Director		Usual Residence of Decedent		79	113.					Sept. 9	), 1	924 01	nio	
	yland		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside C	ity Limits
	Mar e-1 s	ctor	New Jersey Ocean		No	orth Be	ach H	aven						1 □ Yes	2 <b>∑</b> No
	or 28	Director	10e. Street and Number				10f. Zip					l0g. Ci	tizen of What C	ountry?	
	23a	rai	1900 Atlantic	lvenue			08	800				Uni	ted Sta	ates	
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8	ture		15. Decedent		Jai <del>os</del> .	16a. Dece	dent's Usua	d Occupa	tion			16h K	(ind of Busines	hite	
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lar	2 should be and Mental remmetic every		19a. Informant's Name/Relationsh			19b. Mailir	ng Address	(Street a	nd Number	or Rural	Route Number	, City o	or Town, State,	Zip Code)	
Baltimore, Maryland 21215-0036	l and tealth m 27		John B. Garver	Brother	205	6777	Surr	eywo	od Lar				Marylan		7-1568
õ	or Hitch		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation		State Mc	Place of Dispo cemetery, cren ntgome:	natory or of YV	ne or th <b>e</b> r place	) [A]	$\mathtt{pril}^{^{Da}}$	17,	20c. L	ocation - City or	Town, State	
ij	it. Pa		4 ☐ Donation 5 ☐ Other (Sp. 21. Signatured Funeral Service L		Cr	emator:	ium,	Inc.	120	004		Bet	hesda,	Marylan	d
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumetic eny injury or other treumetic enem.		1 NavilE	Deur	М0	0803 B	etheso	la-Ci la, N	nevy ( Maryla	inase and	20814-	350 350	5/ Wisc	uneral onsin A	Home/ venue
þ			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that inly one cause on	caused the dea	th. Do not ent	er the mode	of dying	, such as c	ardiac or	respiratory arr	est,		Approximat Interval Bet	ween
	Physician ·		Immediate Cause (Final disease or condition	_a Me	tastati	c Breas	st Car	ncer						Onset and 1 Year	
	/Medical Examiner		resulting in death)		(or as a conse									1 ICAL	
		7	Sequentially list conditions,	b Due to	(or as a conse	Quence of):									
	ited nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	54010	(0) 43 4 00/130	querice or,									
<u>,</u>	exect n and ial-tra	Exal	that initiated events resulting in death) Last	c	(or as a conse	quence of):						-			
8760,	cate be executed physician and the burial-transit	dicai	7	d.											
9	tificat ig phy as th	0		-											
Вох	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		Ectopic pre						23d. Date of de	livery	
	the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☑No		nant at time of		Other (spe						Month	Day	/ear
P. 0.	that the di ed by the detached	Phy	9 Unknown									i			
Ś	signed be del	by	Part II. Other significant condition	is contributing to c	leath but not res	sulting in the ur	nderlying ca	use giver	n in Part I.				_	the cause of d	
orc	w requir been s should	eted								_	1 🗆 Ye	s 2	XINo 3 □ Pi	robably 4 🗆	Jnknown
Record	e law has b	Completed									24a. Was ar autops	V	prior to	utopsy findings completion of c	available ause of
_											perform	ned? X No	death?	2 🗆 No	
Vital	eicien: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:							Check only one	4		Broti	her's
Division of	ig Phye ter this neral di	1: To	1 ☐ Yes 2 📉 No 27. Manner of Death	1 1 1		ER/Outpatient 28b. Time of		A lnuny	4 🗌 Nurs	ing Home	5 🗌 Reside d. Describe ho	nce 6	6 XOther (Spe	cify) Resi	lence
on	th. : After s funer	tior	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga		of Injury th, Day Year)	Injury	М	lc. Injury a Work?	jn es 2∐No		a. 2000/100 110	W injur	y occurred		
N N	Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place	of Injury - At h	ome, farm, stre	et, factory,	office		281	f. Location (Str	eet an	d Number or Ri	ıral Route Num	ber,
	spitel or ours afte nerel Dir filled in	Cert	4   Homicide	build	ing, etc. (Speci	(y)					City or Town	, State,	)		
	To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  12 Certifying 2 Medical E	Physician: To the xaminer: On the b and man	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred a estigation,	t the time	, date and nion, death	place, and occurred	d due to the ca at the time, da	use(s) ite and	and manner as place, and due	stated. to the cause(s	)
	To th withir To th comp	Me	29b. Signature and title of certifier	- 1	it	1 ^	29c.	License	number		29	d. Date	e signed (Mont	h, Day, Year)	
			+ Yosephi	nichael	Hagger	te, MI	מ	3240	7		Δ	nri	1 16, 2	004	
	19	-	30. Name and address of person w	ho completed caus	se of death (Iter	n 23a) (Type, F		J 4 T U			Δ	L.T.	<u> </u>	.00+	
			Joseph Michael 1	laggerty,	M.D.	9707 M	edica	1 Ce	nter :	Drive	, #300	, R	ockvill	e, MD 2	20850
	Sta Registra		31. Date filed (Month, Day, Year)  APR 1 9 2		t <del>ogis</del> trar's Signa	dature		No. of the last							

-IM			1 - For Amend Item #4	State of b-c per me	Maryland / Depa 0831 5/2//04 to	artment of F	lealth ar Death	nd Mental Hygi	ene 2001	14528
			Decedent's Name (First, Middle, Li	ast)				2. Date of Death	1	3. Time of Death
	Physici		Francis Rud	olph .	Jones			APRIL 9	Day Year 2004	4:37 P M
X	/Medic Examir		4a. Facility Name (If not institution, gi	ve street and numb	per)	Potomac	r Location of	Death	4c. County of Dea	th <b>Y</b>
			GREAT FALLS NATI 5. Social Security Number 6.		Age (In yrs. last birthday)	UPPER If Under 1 Year	MARI PC		PRINCE C	FORCES CO- thplece (State or Foreign
к	Funeral Director			1 <b>⊠</b> M 2□F	74 Yrs.	Months Days		Min. (Month, Day,	Year) C	hington, DC
			Usual Residence of Decedent		/4			raten 21	1930 Was	nington, be
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar	ţō	Maryland Prince	George's	Upper Ma	r1boro				1 ☐ Yes 2X No
	r 28s	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	3a o	0	9703 Wyman Way			20772		Ţ	Jnited Sta	tes
	deat	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S. 13.	Was Decedent of H	lisp <b>an</b> ic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am	
21215-0036	72 hours after death with the Maryland netural', or Items 23a or 28a-f show deat Examinat mant be notified at	by	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 K Yes 2 If Yes, Give Year or Date	□N∘ 1951-	1 Yes 2 No	Specify:	rueno rican, etc.)	Black, Whi	
Ş	"netur	ted	15. Decedent's E			dent's Usual Occup		, , ,	6b. Kind of Business	/Industry
בן ב	C _ 9	Completed	(Specify only highest gi	College (1-4	life.	kind of work done of DO NOT use retired	<i>during</i> most o	r working		
7	filed within Hygiene. other than	FIO.	12	00030 (1	,	-employed			Construct	ion Retail
פ	should be filed of Mental Hygie marked other imatic event, III	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's	Name (First, Middle, M	laiden Sumame)	
<u>a</u>	Mental Mental arked o	To E	Unavailable				Ruby	M. Jones		
Maryland	2 should and Men is marke aumatic	,	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number	or Rural Route Number,	City or Town, State,	Zip Code)
	is 1 and 2 should of Health and Mer- item 27 is marke other traumatic		Walter W. Johnson	n / Atto	rney 8701	Georgia	Ave. #	606 Silver	Spring,	MD 20910
ē,	of Hein of Hein fitem		20a. Method of Disposition		20b. Place of Dispo	The second secon			Oc. Location - City or	
Ĕ	B 0 F F 7		1 Burial 2 XCremation 3 C  4 Donation 5 Other (Spec		Metropoli				lexandria,	Virginia
Baltimore,			21. Signature of Funeral Service Lice	-	The second secon	. Name and Addre				VIIgInia
ñ	permit. Depertrimports eny inji	h 10	/ fugl.	m_	10	E. Deer	Park 1	DeVol Fune Dr. Gaithe	rsburg, MI	
je.	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	sh line.	- War cel				Approximate Interval Between Onset and Death
2	*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	as a consequence of):					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c						
ń	exection and and rial-tr	Exa	resulting in death) Last		as a consequence of):					
8/60,	cate be physicia the bur	edical		d						
9	g phy as th	edi								
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		h 2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
<u>ഗ്</u>	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to dea	th but not resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	10
2	equi	Completed						Yes	2 □ No 3 □ Pi	obably 4 Unknown
ပ္	e law i has bo	ple						24a. Was an autopsy	24b. Were as	utopsy findings available completion of cause of
I	Th page	OIL						perform 11√1)Yes 2	ed? death?	
<u>a</u>	ian: Th rtificate ctor, pag	Bec	25. Was case referred to medical				26. Place of	Death (Check only one		
_	Physician: this certific ral director,	10 E	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inp	atient 2 ER/Outpatien	t 3 DOA Oth	er: 4 ☐ Nursi	ng Home 5 Resider	ice 6XXQther (Spe	city) SCENE
Division of Vital Records,			27. Manner of Death	28a. Date of	Injury 28b. Time of Injury	28c. Injun Worl	at I.	28d. Describe hov	v injury occurred	
<u>o</u>	Attending r death. ector: After by the funer	Certification;	1 □ Natural 5 □ Pending 2 □ Accident investigation	April 1		PM 1□		Subject	shortsell	?
<u>s</u>	or Atten after deat Director: in by the	ific	3 Suicide 6 Could not l	28e. Place of	Injury - At home, farm, str., etc. (Specify)	eet, factory, office	-	281. Location (Stre	et and Number of Ri	ural Route Number,
5	el or A s after al Dire	ert	4 I Homode	ballaling	Velich	in for King	Lit	City or Town,		ally National Bu
	To the Hospitel or At within 24 hours after of to the Funerel Direct completely filled in by	edical (	Chack only 2 Medical Exa	miner. On the bas	est of my knowledge, death	occurred at the tin			use(s) and manner as	stated.
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manne	Stated.	29c. Licensi	number	20	d. Date signed (Mont	h Day Year
M .	T W S		200. Signature and title of certifier	1/			мЕ	29		
1	+1		Theoder,	U. Kert	mo		LT E	400	APRIL 10,	2004
			30. Name and address of person who	completed cans	of death (Item 23a) (Type.			and and and		
1			THEODORE Million	, , ,		TII Pe	on Str	eet, Baltim	ore, Maryl	and 21201
	Sta		31. Date filed (Month, Day, Year)	004 32. Reg	istrar's Signature	Sparks				
	Registr		DIN 61 4	UUT JE	N	pours				
DHN	AH 17 Rev 1/2	001								

ORIGINAL

			For State	State of	Marylan	-	artment of F		d Mental Hy	giene Reg. No. 2 N (	01. 11.	- 0 0
			Registrar     Decedent's Name (First, Middle)	, Last)			rimouto or i	- Jouin	2. Date of De		3. Time of	Death
	Physici		William J.	Jordan					April	20, 20	Year 1004 1:10	ам
	/Medic Examin		4a. Fecility Name (If not institution		iber)		4b. City, Town, or	r Location of De		4c. County o		
	Exami		15300 Pine Ore	chard Driv	e, Apt	. 2B	Silver	Spring	3	Mont	gomery	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H	in. 8. Date of Bir (Month, Da	h v. Year)	Birthplace (State or Country)	r Foreign
	Director		031-01-1710	1 <b>⊠</b> M 2□F	90	Yrs.	Wioritis Days	Tiours iv	April	2, 1913	Massachuset	:ts
	pu 🛾		Usual Residence of Decedent  10a, State 10b, County		10c Cit	y, Town or L	ocation				10d. Inside Cit	ty I imits
	sho	5									1 ☐ Yes	•
	28e-f	Director	Maryland Monta	omery	51	llver	10f. Zip Code			10g. Citizen of Wh	hat Country?	
	with	급	15300 Pine Oro	hard Driv	o Ant	2 R	2090	6		USA		
	leath	Funeral	11. Marital Status	12. Was Dece	dent Ever in U				(Specify Yes or No		- American Indian,	
<b>,</b>	r iten	臣	1 ☐ Never Married 2 🖾 Marr	Armed For led 1 2 Yes	2 🗆 No		If Yes, specify Cuba	ın, Mexican, Pu	uerto Rican, etc.)	Black	White, etc.	
036	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Da		-46	1 ☐ Yes 2 ☒ No	Specify:		Specify:	White	
20	J within 72 hours after death with the Maryland jiene. r than "naturel", or items 23a or 28e-f show tra Modical Examination and the notified at	Completed	15. Deceden (Specify only higher	r's Education		16a, Dece	dent's Usual Occup	ation	workina	16b. Kind of Bus	iness/Industry	
21		ם	Elementary/Secondary (0-12)	College (1	4or 5+)		kind of work done of DO NOT use retired			**	1	
121	illed within Hygiene. other than ent, it e Ma	ပိ		5+		Re	search Bi		Name (First, Middle,	Resear		
and	Ø = 0 = 0	Be	17. Father's Name (First, Middle,	Jordan.				Mary			,	
Maryland 21215-0036	os 1 and 2 should be of Health and Mental litem 27 is marked of other treumatic ever	၉	William J.  19a. Informant's Name/Relations			10h Mail	nn Address (Street		Rural Route Number		itate Zin Codel	2000/
Ma	d 2 s th an t7 is r treur										r Spring, N	2090@ MD
ď,	1 an Heal tem 2		Alvaretta Jorda 20a. Method of Disposition	in/ wire		Place of Disp	osition (Name of		Date		City or Town, State	
<u>o</u>	ages ant of At: If I		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			te_of	matory or other plac Heaven	a) Api	ril 23,   2004	Cilvor C	pring, Mary	ol and
Baltimore,	T to in		21. Signature of Funeral Service	-			tery	ss of Facility	s Funeral			yrand
B	permit Depar Impor any in		Nous S	0-000	_	F:	rancis J. 30 Univer	Collin sitv Bl	s Funeral vd. W. Si	lver Spr	c. ing, MD 20	901
			23a. Part Enter the disease, or shock or heart failure. List	complications that co	used the deat						Approximate Interval Betw	9
	Physician		Immediate Cause (Final disease or condition			har					Onset and D Years	Death
	/Medical		resulting in death)		omyopat or as a conseq						Tearb	
	Examiner		Sequentially list conditions,	b. Coron	ary Art	ery D	İsease				Years	
	p =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseq	uence of):						
	ecute and trans	Exami	Cause (Disease or injury that initiated events resulting in death) Last	c. Essen	tial Hy		nsion				Years	
8760,	cian a	<u> </u>	Todaking in doday back	Due to (	or as a conseq	uence or):						
187	the death certificate be executed y the attending physician and sched for use as the burial-transit	dical		d								
9 X	eath certific attending p	/We	IF FEMALE:	23c. If yes, out	come of pregna	ancy				23d. Date	of delivery	
Вох	atten atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live bi	nth 2 ☐ Feta ant at time of d	Ideath 3	□Ectopic pregnancy □ Other (specify)			Mont	•	/ear
o.	at the de by the a tached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno			., .,		,			
٦.	å å å	by Pi	Part II. Other significant condition	ons contributing to de	ath but not res	ulting in the t	underlying cause giv	en in Part I.	23e. Did t	obacco use contrib	oute to the cause of de	eath?
rds	w requires been sign should be	pa pa	Diabetes Melli	tus- Type	II				101	res 2□No 3	B Probably 4 ⊠U	Inknown
Vital Records,	law re as bee 2 sho	ompleted							24a. Was		ere autopsy findings a ior to completion of ca	available
Ä	The I	E							perto	rmed? de	ath? □Yes 2□No	
ita	lan: rtifica stor, p	BeC	25. Was case referred to medica					26. Place of I	Death (Check only o	ne)		
	Physician: this certific al director,	P	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 □ II	npatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursin	g Home 5⊠ Resid	dence 6 □Other	(Specify)	
n of	fter ne		27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date of (Monte	f Injury h, <i>Day Year)</i>	28b. Time o Injury	Wor	k?	28d. Describe I	low injury occurred	d	
sio	at at	cati	2 ☐ Accident investing 3 ☐ Suicide 6 ☐ Could	gation				Yes 2 □ No	200 1	24		
Division	al or Attendii after death. I Director: A d in by the fu	Certification;	4 Homicide determ	ined 200. Place	of Injury - At h ig, etc. <i>(Specil</i>		reet, factory, office		City or Tov	otreet and Number vn, State)	r or Rural Route Numb	ber,
	Hospitel Hospitel Funerel Funerel Hely filled	1	29a, Certifier 1 🔀 Certifyir	g Physician: To the	hest of my kno	wledge dea	th occurred at the tin	ne date and ni	ace, and due to the	cause(s) and man	ner as stated	
	To the Hospitel or Atte within 24 hours after de To the Funerel Direct completely filled in by th	Medical	(Check only 2 Medical one)	Examiner: On the ba	sis of examina	ition and/or is	vestigation, in my o	pinion, death o	ccurred at the time,	date and place, an	nd due to the cause(s)	)
	To the vithin To the compl	Me	29b. Signature and title of certifie	mA			29c. Licens	e number		29d. Date signed (	(Month, Dey, Year)	
			18mgn				D239	58		April 2	20, 2004	
	5		30. Name and address of person									
) —			Burt I. Feldm				re World	Blvd.,	Silver Sp	oring, MI	20906	
	Sta		31. Date filed (Month, Day, Year) APR 2.1	2004 32. 1	egistrar's Signa	ature 4	Sparks	1				
1	Registi	ar	MER 21	7004	1		payours					

	_		1 - For State Uppend III Registrar  1. Decedent's Name (First, Mine)	State of Men#23a,27,HR ME,	C831,5726704	Rificate of	Death		1	17000
	Physic /Med	ical.	p.	DARRELL WA				2. Date of Deat Month April	17, 2004	3. Time of Death 11:33 A <sup>M</sup>
2245	Exam Funera Director		4a. Facility Name (If not institute 910 Kent Morris 5. Social Security Number 212-72-5035	Road  6. Sex 7. Ag  7. Ag	ge (In yrs. last birthday 46 Yrs.	Ste	PVensville  If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/6/19	Year) 9. Birth	h Anne's  hplace (State or Foreign untry) YLAND
0	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Marijeal Examinar must be malfilled.	Director			10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2X No
	ath with t	ral Dir	10e. Street and Number 2743 LITTLE	ESTOWN PIKE		10f. Zip Code 21158	3	10	Og. Citizen of What Cor USA	untry?
9036	ours after des rei', or Items Examinar m	by Funeral I	11. Marital Status 1 ☐ Never Married 2 🛣 № 3 ☐ Widowed 4 ☐ Divord	If Vas Give	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	lispanic Origin? (Spe an, Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: WH	e, etc.
Maryland 21215-0036	Ten 122 has 1888	Completed	15. Decec (Specify only hig Elementary/Secondary (0-12 1 2	dent's Education shest grade completed)  College (1-4or 5	(Give	edent's Usual Occup e kind of work done DO NOT use retired FOREMAI	during most of workir d)	ng	66. Kind of Business/	
yland	s 1 and 2 should be filed if Health and Mental Hygis frem 27 is marked other other treumetic event, the	To Be C	17. Father's Name (First, Midd DAF	RRELL WALTZY	JONES,		18. Mother's Name JOYCE A	. FAUBI	ER	
	as 1 and 2 sh of Health and item 27 is m		19a. Informant's Name/Relation  CAROL M. JON 20a. Method of Disposition	NES - WIFE	2743	LITTLES	STOWN PI	KE,WEST	City or Town, State, Zir CMINSTER, Oc. Location - City or T	MD.21158
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre once.		1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other 21. Signatu of Euro 1 Servi		EVERGREI 2	EN MEM . G	ARDENS 4	TCHER	FINKSBUF FUNERAL F	HOME
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	Cardion	the death. Do not en				NSTER, MI	Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>1</b> c	a consequence of): a consequence of):				//	
P.O. Box 68	The law requires that the death certific tle has been signed by the attending pl tage 2 should be detached for use as I	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
rds, P	w requires that been signed b should be deta		Part II. Dther significant condi	itions contributing to death bu	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to the	he cause of death?
		Completed						24a. Was an autopsy performe	ed? death?	psy findings available impletion of cause of 2 No
of	ending Physeath. or: After this he funeral di	Certification; To Be	100.00111	Hospital: 1 ☐ Inpatier  28a. Date of Injur (Month, Day stigation		28c. Injury Wark	4   Nursing Home		ce 6 X Other (Specif	) SCENE
Divi	e Hospitel or Att 124 hours after d 9 Funerel Direct letely filled in by t		4   nomicide	mined 286. Place of Inju building, etc				City or Town, S	•	
	문문문	Medical	one)	ring Physician: To the best of all Examiner: On the basis of and manner states	examination and/or inv	estigation, in my op	inion, death occurred	at the time, date	and place, and due to	the cause(s)
	WIL		29b. Signature and title of certif	- Me Shell	un	29c. License	O.C.M.E.		. Date signed (Month, $18$ , $2$	
2_	0		30. Name and address of perso	A. KORELL	111		et, Balti	more, Ma	aryland 212	201
1	Sta Registr	_	31. Date filed (Month, Day, Yea APR	2 2 2004 Registrat		hood .				

			1 - For State Registrar	State of Marylan	nd / Depa		lealth and I	Mental Hygi		14531
	Physici /Medio		Decedent's Name (First, Middle, Last) Gertrude-Mary Jone	es				2. Date of Death Month April 8	Day Year	3. Time of Death 5:24A. M
	Examir		4a. Fecility Name (If not institution, give s Laurel Regional Ho			Laurel	r Location of Death		4c. County of Dea Prince G	eorge's
	Funeral Director		0 11 000	M ADE	last birthday) 72 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 23,	<sup>9. Bir</sup> 1931 Ne	thplece (State or Foreign ountry) W Jersey
	Aaryland f ehow	or	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince Geo		ty, Town or Le				***	10d. Inside City Limits 1 ☐ Yes 2√ No
	death with the Maryland ms 23e or 28e-f ehow rmat be notified at	Director	10e. Street and Number 11708 Pine Street			10f. Zip Code 2070	)5	10	g. Citizen of What Co	
920		by Funeral		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2↓ No If Yes, GiveA Year or Dates:		Was Decedent of Hif Yes, specify Cub		pecify Yes or No- o Rican, etc.)	United S  14. Reca - Am Black, Whi  Specify:	erican Indian,
Maryland 21215-0036		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor d)	king	6b. Kind of Business	,
and z	d ta b	To Be Col	12 17. Father's Name (First, Middle, Last) Raymond Lloyd John	1-4 nson	Cater	er		ne (First, Middle, Ma	<u>Self—Empl</u> aiden Sumame) h Shroede:	-
	2 should and N	1 3	19a. Informant's Name/Relationship (Type Richard Jones -Hus	pe, Print)			and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, cre	osition (Name of matory or other pla	сө)	Date 20	Oc. Location - City or	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service License  Locale ( )  23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	9 - 1	2: D	2. Name and Addre	ss of Facility Borgward	t Funeral	Home. P.	Α_
	Physician /Medical		shock, or heart failure. List only or Immediete Cause (Final disease or condition resulting in death)	Sepsis  Due to (or as a consec		ter the mode of dyn	ig, such as caldiac	- Or respiratory arres		Interval Between Onset and Death 6 days
68/60,	rcate be executed xamphysician and physician and street transit	dical Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that infineded events resulting in death) Last	Due to (or as a consect						
O. BOX 6	The law requires that the death certificat ate has been signed by the attending phy cage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	⊒Ectopic pregnance	4		23d. Date of de Month	livery Day Year
ds, r.	juires that I n signed by ild be deta	þ	Part II. Other significant conditions cor End Stage Renal I	•	sulting in the u	underlying cause gr	ren in Part I.			o the cause of death?
II Kecords,		Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?	lospital:	] ED/O-4	- all pos   Ott	ar	th (Check only one)		
Division of	After	H-	1 Yes 2 XNo  27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	1 X Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injur	4 🗀 Nuising n	28d. Describe how	ce 6 Other (Spe v injury occurred	city)
Divisi	ol or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 X Certifying Physical Check only 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the tin exestigation, in my o	me, date and place opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as e and place, and due	s stated. a to the cause(s)
	withi To ti	Ž	29b. Signature and tilk of certifier	7	(B)	29c. Licens D544			d. Date signed (Mont April 8, 2	
)			30. Name and address of person who con Bennett So., M.D.	8317 Cherry 1	Lane La		ryland 20	707		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	ature &	Societa	1			

		1 - For State Registrar	State of Man	yland / D	epartme Certifica	nt of He	alth and	Mental Hy	giene Reg. No	2004	14532
Physici		1. Decedent's Name (First, Middle, I Sylvia	Mercedes	J	oseph	5		2. Date of De. April		, 200 <sup>4</sup> ar	3. Time of Death 9:08p M
/Medio Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City	, Town, or Lo	ocation of Dea	th		. County of Death	
		Casey House				ockvi				Montgom	
Funeral Director		5. Social Security Number 117-58-2505  Usual Residence of Decedent	Sex 1 □ M 2 ☑ F 86	n yrs. last birth Y	rs. Months		f Under 24 Hr Hours Mir		19 1 1 9 1	7 Ci	place (State or Foreign ntry) 1ba
faryland febow	or	10a. State 10b. County  MD Montgo		Oc. City, Town	or Location	ring				1	1 Od. Inside City Limits 1 ☐ Yes 2 🙀 No
the h	rect	10e. Street and Number	7021			ip Code			10g. Ci	tizen of What Cour	ntry?
h with	alD	3830 Tynewich	Drive		2	0906			US	A	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or iteme 23a or 28e-f ehow importent: If item 27 is marked other than "netural", or iteme 23a or 28e-f ehow any intry or other treumatic event, the Medical Examiner must be natified at once.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S.		edent of Hisp ecify Cuban, 2 <sup>M</sup> No		Specify Yes or No rto Rican, etc.)	)-	14. Race - Americ Black, White, Specify: B	
in 72 hou n "netural Medical E	pieted b	15. Decedent's (Specify only highest (Secondary (0-12)	Education	16a.	  Decedent's Us  Give kind of w  life. DO NOT	ual Occupation ork done dur use retired)	on ing most of w	orking	16b. K	(ind of Business/In	dustry
d with giene er the	E	8			Homem	aker			0	wn Home	
al Hy al Hy al othe vent,	Be	17. Father's Name (First, Middle, La	st)			11	8. Mother's Na	ame (First, Middle,	, Maider	Sumame)	
Ment Ment arkec	2	Richard Howe						nknown			
12 sho n and 7 is m		19a. Informant's Name/Relationship Felicita D.Rol	o <i>(Type, Print)</i> Dinson/Dauc	thter	Mailing Addre	ss <i>(Street and</i> Tynew	ick D	Rumal Route Numbe rive Si	өг, City ( lve	or Town, State, Zip r Sprin	<i>∘2</i> €0906 .a.Md
1 and Health em 27		20a. Method of Disposition		20b. Place of	Disposition /N	ame of		Date		ocation - City or To	
ages ont of it: if it		1 Burial 2 Cremation 3			of He		4/1	9/04	Si	lver Sp	ring,MD
permit. P Departme Importen any injur		21. Signature of Funeral Service Unit								SERVIC r Sprin	E,P.A. g,Md2091
Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final						ac or respiratory a	rrest,		Approximate Interval Between Onset and Death month
/Medical Examiner	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cerebrouse to (or as a composition of the compos	consequence o	of):	acciu	EIIC				MOTETI
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 [ 4□Pregnant at tin 9□Unknown	Fetal death	3 ⊟Ectopic 5 ☐ Other (					23d. Date of delive	ery Day Year
requires that I een signed by hould be deta	by	Part II. Other significant condition	s contributing to death but r	not resulting in	the underlying	cause given	in Part I.				he cause of death?
The far	Completed							24a. Was autor perfo	psy ormed?	prior to co death?	opsy findings available impletion of cause of
Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	•		Othor		eath (Check only o		a <b>10</b> 00 - 10 - 10	w hospice
fter	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Y	2 ☐ ER/Out 'ear) 28b. T In		28c. Injury a Work?	4   Indistrig	28d. Describe			y) NOSPICE
	Certification:	3 Suicide 6 Could no determin		- At home, far (Specify)	rm, street, facto	bry, office		28f. Location ( City or To		nd Number or Rura e)	al Route Number,
To the Hospitel or within 24 hours after To the Funerel Direction Completely filled in	Medical C		Physician: To the best of reminer: On the basis of example and manner state.	camination and							
To the I within 2 To the I complet	Me	29b. Signature and title of tertifier	L	~	0	9c. License r D3563			29d. Da	ate signed (Month, onl 13,	Dey, Year) 2004
·V		30. Name and address of person w Joseph Kaplar	completed cause of dea MD 6001	th (Item 23a) ( Munca	Type, Print) aster	Mill	Rd R	ockvill	e,M	ID 20855	
St. Regist	ate	31. Date filed (Month, Day, Year) APR 15	2004 32. Registrar's	s Signature	6 4	souks	/				

			1- For State of Maryland / Dep Registrar Ce	artment of Health and Mental Hertificate of Death	ygiene 2004 1453:
ľ	16. 1		1. Decedent's Name (First, Middle, Last)	2. Date of D	Death 3. Time of Death
	Physici /Medi		Mary E. Johnson	Month April	$\begin{array}{c c} 12^{\text{Day}} 2004^{\text{Year}} & 0350 & \text{M} \end{array}$
	Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
			Anne Arundel Medical Center	Annapolis	Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. 8. Date of B	
	Director		220-16-7459 Yrs.  Usuel Residence of Decedent		.8 1921 Maryland
	and w		10a. State 10b. County 10c. City, Town or L	Ocation	10d. Inside City Limits
	Many	ō	Maryland Anno Arundol Anno 1		1 ☐ Yes 2型 No
	the 286	Director	Maryland Anne Arundel   Annapol:	L S 10f. Zip Code	10g. Citizen of What Country?
	3a or		1446 Log Inn Road	21401	
	death ms 2	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Specify Yes or N	USA
36	72 hours after death with the Maryland natural; or items 23s or 28e-f show dissi Exantras trast be rediffed at	by Fur	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No   If Yes, specify Cuban, Mexican, Puèrto Rican, etc.)  1 ☐ Yes 2♥ No Specify:	Black, White, etc.  Specify: Black	
21215-0036	72 hounatura	ted	15. Decedent's Education 16a, Dece	dent's Usual Occupation	16b. Kind of Business/Industry
215	드 프	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	Too. Talk of Eddinosamasary
2		Om	8th 0	Domestic	Private Family
D	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
yla		To	Augustus Parker	Isabell Ow	rens
Maryland	2 should and Mile mari			ng Address (Street and Number or Rural Route Numb	
	s 1 and 2 should if Health and Mer Item 27 is marks other traumatic			01 N. Eutaw St. Apt.	
D	or of		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State  Ref. 1 Carte 1	psition (Name of Date matory or other place)  Memorial	20c. Location · City or Town, State
Baltimore,	it. Partmer		Park Park	4/16/04	Annapolis, Md.
Ba	permit. Pages 'Department of Findorstant: If Ite any injury or of Quee.		MA MARKER V	2. Name and Address of Facility Jm. Reese & Sons Mort 321 West St. Annapoli	uary, P.A. s. Md. 21401
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory a	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	anevysm	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		
		<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	ted nsit	Examiner	Cause. Enter Underlying		
	al-tra	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
38760,	cate be executed physician and the burial-transit	dlcal			
W.	tificat g phy as the	(D)			
Вох	h cert endin	M/UR	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Te analis assessment	23d. Date of delivery
	The law requires that the death certifi tie has been signed by the attending rage 2 should be detached for use as	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	Month Day Year
<u>О</u>	at the	Phy	3 Ottkilowit		
Ś	res th	þ	Part II. Other significant conditions contributing to death but not resulting in the u		tobacco use contribute to the cause of death?
50	v requir	eted	Cardiony ope hy		Yes 2 No 3 Probably 4 □Unknown
Record	e law has t	Completed	,	24a. Was	psy prior to completion of cause of
<u></u>				pend 1 □ Yes	ormed? death? 2000 1 Yes 2 No
Vital	ysician: is certific director.	o Be	25. Was case referred to medical examiner?	26. Place of Death (Check only of Other:	
o	Phys or this oral di	$\vdash$	1  Yes 2	4   Nursing Home 5   Hesi	dence 6 Other (Specify) how injury occurred
0	Attending Physician: r death. ector: After this certificity the funeral director.	tlor	↑ Natural 5 Pending (Month, Day Yeer) Injury 2 Accident investigation	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	now analy occurred
Division of	or Attendi after death. Director: A in by the fa	ific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str		Street and Number or Rural Route Number,
		Certification:	4 Homicide building, etc. (Specify)	City or To	wn, State)
	To the Hospitel or Al within 24 hours after or To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one)  American Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, and due to the restigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and Mile of certifier	29c. License number	29d. Date signed (Montil), Day, Year)
<b>&gt;</b>			MA L MO	D5518+	Y/12/04
)			30. Name and address of person and completed cause of death (Item 23a) (Type,	Print) A. J. ( M )	Car few
	Sta		31. Date filed (Month, Dey, Year) 32. Registrar's Signature	I IVEROLC   TEOLIC	at 1000
	Registra	ar	APR 1 5 2004	and the same of th	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9, Annie Eberhardt Jowett Apr. 2004 2:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Heartlands of Severna Park Severna Park Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 23, 1906 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 212 F 98 AL Yrs. 216-44-6843 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show amy injury or other treumatic event, the Medical Examinations is not contact. MD Anne Arundel Severna Park 1 ☐ Yes 2 XNo Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 715 Benfield Road 21146 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Lab Technician HIN18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frederick S. Pearson Annie Eberhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della Horne/Granddaughter 45312 Elmbrook Drive, California, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Apr. 10, 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory • 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Hot 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Pineral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INFARCTION **Physician** HOUTE MYOLARDIAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uaknown ONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1 Yes 21100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED HVING Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 2 ☐ M6 Medical Certification; To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 BNatural 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

use as the burial-transit The law requires that the death certificate be executed and the attending physician Division of Vital Records, P.O. Box 68760, ò should be peen has certificate or Attending Physician: hours after death.

Inerel Director: After this y filled in by the funeral di this within 24 hours a To the Funerel 6 completely

Baltimore, Maryland 21215-0036

Registrar

DHMH 17 Rev 1/2001

State

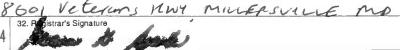
(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2004

Nec

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

29c. License number

057531

29d. Date signed (Month, Day, Year)

		Please I	State of Mandar			=	-	
		For State	State of Marylar	Certificate				4 14535
		Registrar  1. Decedent's Name (First, Middle, Last)		Certificate	or Death	2. Date of Death	g. No.	3. Time of Death
Physic			dward	Johns		APRIL	17 2004	
/Med		James Ed			own, or Location of Death	1111111	4c. County of Dea	
Exami	ner	1 1	spice	E	-aston		Talbo	+
Funeral		5. Social Security Number 6. Sex		last birthday) If Under 1		8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
Director		X17-02-6170	JM 20 F	Yrs.		Oct. 19,	1425 M	aryland
and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Location				10d. Inside City Limits
Maryl. f sho	ō	MD Talbo	+	Fastor				1 Nes 2 No
	rec	10e. Street and Number		10f. Zip (		10	g. Citizen of What C	ountry?
15-0036 / C	Funeral Director	123- Port	Street		21601		USA	•
deat	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was Decede If Yes, speci	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
s after	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗹 No If Yes, Give	1 ☐ Yes 2	No Specify:		Specify: 2	ank
5-UU36 72 hours af natural, or		15. Decedent's Edu	Year or Dates:	16a. Decedent's Usual	Occupation	1	6b. Kind of Business	ack Vindustry
in 72	Completed	(Specify only highest grad	e completed)	(Give kind of work life. DO NOT use	done during most of work	king		
d within jiene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Farn	1er	<i>[</i> -	rivate	Residence
othe vent,	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, M	laiden Sumame)	
arylar should b nd Ments i marked umatic e	To	Joseph	JOHNS		EMM			
2 a a a		19a. Informant's Name/Relationship (T)		19b. Mailing Address	(Street and Number or Ru	_ ,	City or Town, State, Mary 19	1
re, N s 1 and f Health item 27 other tr		Constance C 20a. Method of Disposition	10/1:NS	Place of Disposition (Nam			Oc. Location - City or	
O 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crematory or oti	(PMetery 4/3		Easton	17 %
<b>Baltim</b> C permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		usen Esther	Address of Ficility	1101 6	2001010	viuryiuroa
Balt permit. Depart Import	į.	Drewallo, a	2 Dourson	Henr	Address of Ficility y Funeral yashington	St. COM	bridge N	10,2/6/3
		23a. Part Enter the disease, or complished, or heart failure. List only o	ications that caused the lea	ath. Do not enter the mode	of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physician		Immediate Cause (Final	/ n	ma Her	d's Neck			Onset and Death
/Medica		disease or condition resulting in death)	a. Due to or as a conse		10 3 1001			
Examine		Sequentially list conditions.	b					
p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Liter Uncerlying Cause (Disease or injury	Due to (or as a conse	quence of):				
60, be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c	iquence of):				
Box 68760, eath certificate be executed attending physician and for use as the burial-transi	calE		d					
687 ifficate g phys								
Box eath cert	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1☐Live birth 2☐Fet	nancy tal death3 □Ectopic pre	agnancy		23d. Date of de	
death	sicia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of 9☐Unknown				Month	Day Year
IS, P.O.	Physician/Medi	9 Unknown  Part II. Other significant conditions co		equiting in the underlying on	nuce group in Part I	23e Did tob	acco use contribute t	to the cause of death?
I Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the	ğ	Part II. Other significant conditions co	Intributing to death out not re	sauting at the differrying co	tose given in i arti.			robably 4 Unknown
Cord w require been signered	eted					24a. Was ar	24h Were a	utopsy findings available
II Rec The law cate has t	Completed					autopsy perform	prior to death?	completion of cause of
Vital Ficien: The certificate rector, pag		25. Was case referred to medical			26 Place of Dea	1 ☐ Yes 2 th (Check only one		s 2 No
Vii s cert	To Be	avaminar?	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatient 3 ☐ DO	Other	ome 5 Reside		ecity) Hospice
g Phy gerthi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 29	8c. Injury at Work?	28d. Describe ho		
vision of Vital Attending Physicien: or death. sector: After this certifical	atio	2 Accident investigation		М	1 ☐ Yes 2 ☐ No		111 1 6	18 4 11 1
Division of Vital Records, for Attending Physicien: I or Attending Physicien: The law requires tatler death.  Director: After this certificate has been signe in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory cify)	, office	City or Town	eet and Number or F , State)	lural Houte Number,
pital of purs all peral of illed i	Se	29a. Certifier 1 Certifying Phy	sicien: To the best of my kr	nowledge, death occurred:	at the time, date and place	and due to the ca	use(s) and manner a	s stated.
DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exem	iner: On the basis of examir and manner stated.	nation and/or investigation,	in my opinion, death occu	rred at the time, da	ite and place, and du	e to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	) _		. License number		d. Date signed (Mon	
		1 ( ) /		DO 1	H41818		4-20-5	.004
		30. Name and address of person who o	ompleted cause of death (Ite	em 23a) (Type, Print)	Jdlewid	1	7-0-1	11/2 21/
		31. Date filed (Month, Day Wan 2	1 20 BMR egistas sign	508	Jalewid	TUC	Chiston	WI 13 21601
_	tate	OT. Date med (Mortin, Day 11a)	T Chot	a st fine	W.			

4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** IRCLE Manore Mortgomeri aliner rensington If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1**X**0 M 2□ F Months 38 2268 224 7a Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-1 show other traumatic event, the Medical Examiner must be notified at DC Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö United States 20017 or itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1□Yes 2No Specify þ 3 Widowed 4 □ Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "I any injury or other traumatic event, it a Mea. Elementary/Secondary (0-12) College (1-4og 5+) erk Weak 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mattie Johnson Jaseph 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Falls Rd Terrace Intermore MD 21210 Laughter 5103 aken Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔏 Burial 2 ☐ Cremation 3 ☐ Removal from State tarmony Memorial Cem 04 17/04 and over, \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John N T. Phines Company 21. Sanature of Juneral Service Lice Washington DC 20017 10 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician CORDNARY DISEASE /Medical Due to (or as a consequence of) **Examiner** OBSTRUCTIVE PULMORY DISENSE HEONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner

ehnson

Approximate Interval Between Onset and Death

IF FEMALE:

Physiclan/Medlcal

Completed

Be

P

Certification:

Medical

1 - For State Registrar

**Physician** 

/Medical

Decedent's Name (First, Middle, Last)

leginala

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Dunknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

9 Unknown

Due to (or as a consequence of):

3 Ectopic pregnancy

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 U 0 4

2. Date of Death

PRI

Month Day

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Year

3. Time of Death

9. Birthplace State or Foreign

Dervice

10d. Inside City Limits

1 XYes 2 No

Virginia

2004

Black, White, etc.

Specify: Black

County of Death

6:10 am

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

2 12 No

1 Tyes

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27 Manner of Death

1 Matural

2 Accident

3 Suicide

29a, Certifie

4 Homicide

29c. License number

2005

29d. Date signed (Month, Day, Year)

1413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 Could not be

determined

tark

4/14/04

31. Date filed (Month) Day, Year)

APR 1 6 2004

32. Registrar's Signature

DHMH 17 Rev 1/2001

**ORIGINAL** 

Box 68760. 1205×HO Records, P.O.

of Vital

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the attending physician hed for use as the buria

been signed by

illed in by the funeral director,

after death. Diractor: After To the Hospital | within 24 hours at To the Funeral D Hospital

State Registrar

			Please  1 - For State Registrar			Depa		. Ensure All ( lealth and Me Death	ntal Hygier	9	
· ·	Physici		Decedent's Name (First, Middle, Las     Sumintra Jagessa			201		2.	. Date of Death	Day Year 2004	3. Time of Death
	/Medid Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Death		4c. County of Dea	
	Exami		Prince George's M	edical Ce	nter		Chever1	v	P	rince Ge	orge
	Funeral Director		5. Social Security Number 6. Se		je (In yrs. last bii 79	rthday) Yrs.	If Under 1 Year Months Days		Date of Birth (Month, Day, Yea ept. 26,	9. Bi	rthplace (State or Foreign country)
	D > 10		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or los	nation				10d. Inside City Limits
	e Maryla le-f shov	ctor	Maryland Prince G	eorge	Landove						1 Yes 2 No
	th with th	Funeral Director	10e. Street and Number 6500 Perry Street				10f. Zip Code 20784			S.A.	country?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Examinational Lectualitied at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Am Black, Wh Specify: B1	ite, etc.
Ŏ	2 ho	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a	. Deced	ent's Usual Occup	pation	16b.	Kind of Busines	s/Industry
Maryland 21215-0036	iene. r than "r r than "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) Ho		aker	during most of working d)	1	vn Home	
D	Hyg other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Name (F	irst, Middle, Maid	en Sumame)	
au	lid be ked ic ev	To B	Mr. Ragoonan					Unob	tainable		
a Z	shound M	-	19a. Informant's Name/Relationship (7	ype, Print)	198	b. Mailing	g Address (Street	and Number or Rural R	Route Number, Cit	y or Town, State,	Zip Code)
Š	nd 2 aith a 27 is		Sandy S. Hall, Da	ughter	650	00 P	erry St.	, Landover	Hills, N	D 20784	
Baltimore,	s 1 a if Hei item othe		20a. Method of Disposition		20b. Place o	of Dispos	sition (Name of natory or other place	Date	1	Location - City o	
e E	Page ent o nt: #f ry or		1 🔀 Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Spe#ify					tery4-6-200	D4 Bre	entwood,	Maryland
Ē	artin ortan		21. Signature of Funeral Service Licen	1		22.	Name and Addre	ss of Facility Fort			•
ä	Depariment Department on the once.		Man 172	bun	_	340	1 Bladen	sburg Rd.,	Brentwoo	runerai d. MD 2	ноте N722
760,	Physician and bhysician and bhysician and streep burial-transit	cal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respir Due to (or as b. Pneumo Due to (or as	atory Fa	ailu of):					Interval Between Onset and Death
P.O. Box 687	death certif e attending ed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death		Ectopic pregnancy Other (specify)	/		23d. Date of de Month	elivery Day Year
	s that pned b e deta	by PI	Part II. Other significant conditions co		_	in the un	derlying cause giv	en in Part I.	23e. Did tobacc	o use contribute	to the cause of death?
ğ	w require been signature		Diabetes Mellitus	, Hyperte	nsion				1 🗆 Yes	2 □ No 3 □ P	robably 4 🕅 Unknown
Reco	hysician: The law requires that the his certificate has been signed by th I director, page 2 should be detach	Completed							24a. Was an autopsy performed 1 ☐ Yes 2 ☑ 1	prior to death?	utopsy findings available completion of cause of s
ita	ian: rtifica	Be C	25. Was case relerred to medical					26. Place of Death (C			
<b>&gt;</b>	Physician: r this certificanal director, in	10	examiner? 1 ☐ Yes 2X No	Hospital: 12 Inpati	ent 2□ER/O	utpatient	t 3□ DOA Oth	er: 4 🗆 Nursing Home	5 Residence	6 ☐Other (Spe	acify)
Division of Vital Records,	ing P	Certification:	27. Manner of Death 1 ⅓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ury 28b.	Time of Injury	28c. Injur Wor	yat 28d k? Yes 2 □ No	d. Describe how in	jury occurred	
Dİ <u>X</u> i	tal or Attend s after death al Director: / ed in by the f	Certific	3 Suicide 6 Could not be 4 Homicide determined	289. Place of In	jury - At home, la tc. <i>(Specify)</i>	arm, stre	eet, factory, office	28f	. Location (Street City or Town, St	and Number or F ate)	lural Route Number,
	the Hospital thin 24 hours a the Funeral I mpletely filled	edical	29a. Certifier (Check only one) 2 Medicel Exam	ysician: To the best niner: On the basis of and manner st	of examination as	je, death nd/or inv	occurred at the tir restigation, in my o	me, date and place, and pinion, death occurred	at the time, date a	and place, and du	e to the cause(s)
•	To the vithin To the comple	Σ	29b. Signature and title of certifier	Di	200	6	29c. Licens D-34			oril 15,	
2			30. Name and address of person who of S. J. Rao, M.D.	4000 Mitc	hellvil	le R	d., #220	, Bowie, MI	20716		
	St	ate	31. Date liled (Month, Day, Year)	32. Regist	rar's Signat <del>ure</del>	Pari	20	-			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

			partment of Health and Melertificate of Death		2004 14539
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Lawrence Carroll Johnson  4a. Facility Name (If not institution, give street and number)  16509 Ariel Court	4b. City, Town, or Location of Death  Bowie	Date of Death Month 4 1	Day Year 1 04 8:00 P M  4c. County of Death  Pr Geo Co
Funeral Director		5. Social Security Number $ \begin{array}{ccccccccccccccccccccccccccccccccccc$		Date of Birth (Month, Day, Young)	2 King Geo., VA
the Maryland 28a-f show	rector	10a. State 10b. County 10c. City, Town or MD Pr Geo Bowie	Location  10f. Zip Code	10g	10d. Inside City Limits  12 Yes 2 No
NOTE, INTRYISTIC 2 12 15-0030  ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  It of Health and Mental Hygiene.  It of Health and Mental Hygiene.  It is marked other than "netural", or items 23e or 28e-f show or other traumetic evant, the Medical Example of Thurst be instiffed at	by Funeral Director	1 □ Never Married 2 ☑ Married 1 ☒ Yes 2 □ No	20716  3. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric		USA  14. Race - American Indian, Black, White, etc.  Specify: Black
Maryland ZIZ 13-0030 of 2 should be filed within 72 hours aft this and Marial Hygiens "netural", or 27 is marked other than "netural", or traumetic event, the Madical Exam	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of working b. DO NOT use retired) uditor		b. Kind of Business/Industry  S Government
laryland 414. 2 should be filed within and Mental Hygiene. is marked other than aumetic evant, the Manal Hygiene.	To Be Co	17. Father's Name (First, Middle, Last) Frank Johnson	18. Mother's Name (F Clara Ruth	rirst, Middle, Ma n nee Jo	iden Sumame) Dhnson
OTC, IMBE es 1 and 2 sh of Health and if itam 27 is in r other traum		Geraldine Johnson – Wife  20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  20c. Place of Disposition of Disp	illing Address (Street and Number or Rural R <b>99 Ariel Court, Bowie</b> sposition (Name of rematory or other place)  Date	e, MD 20	0716 c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hez Important: If item any injury or othe		`4 □ Donation 5 □ Other (Specify) CheItenna  21. Signature of Funeral Service Licensee	am Cemetery 4-16-0 22. Name and Address of Facility Bell 5503 Old Branch Ave.	l Funera	neltenham, MD al Home PA Hills, MD 20748
BOX 68 / 60, auth certificate be executed attending physician and for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or highly that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	enter the mode of dying, such as cardiac or re	espiratory arrest	Approximate Interval Between Onset and Death
hat the death certificated by the attending phydetached for use as the	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
The CONDS, P.O. Dr. The law requires that the death the has been signed by the atter age 2 should be detached for u	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknow
- 0 -	Completed	25. Was case referred to medical	Of Plant of Doob (		24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
on of ling Phys n. After this funeral di	Certification; To Be	examiner?	y Work? M 1 ☐ Yes 2 ☐ No	5 🛣 Residence d. Describe how	et and Number or Rural Route Number,
To the Hospitel or Attant within 24 hours after deat To the Funaral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, do and manner stated.  29b. Signature and title of certifier	eath occurred at the time, date and place, and rinvestigation, in my opinion, death occurred  29c. License number	at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)  I. Date signed (Month, Day, Year)
Sta Registr		30, Name and address of person who completed cause of death (Item 23a) (Tyl  10	De, Print)  USC. ANP.	#1125 CV	very Chase m3

ORIGINAL

	•	For State Registrar	State of Marylar		artment <i>rtificate</i>				Re	g. No.	2004	1454
		1. Decedent's Name (First, Middle, La	ast)					2	Date of Death Month	Day	Year	3. Time of Death
Physici /Medi	al	Joyce	Jackson						4	14	2004 County of Death	9:00A M
Examir		4a. Facility Name (If not institution, gi			4b. City, T		Location o	f Death			,	
		Southern Maryland	I HOSPITAL  Sex 7. Age (In yrs.	last hirthday	If Under 1		nton If Under 2	24 Hrs.   8	Date of Birth		Prince G	
Funeral		5. Sociat Security Number 6. 577–72–9158	1□ M 2ĂF 7. Age (117 y/s.	Ven	Months	Days	Hours	Min.	Date of Birth (Month, Day, av 29 ]	Year)	Mary Mary	place (State or Foreigr ntry) I and
Director		Usuel Residence of Decedent			1			Į.i.	ay 23 3			
/land		10a. State 10b. County	10c. C	ity, Town or L	ocation						1	10d. Inside City Limits
Man Filed	io	MD Prince	George's	Chel	tenham	1						1 X Yes 2 □ No
h the	lre	10e. Street and Number			10f. Zip (					-	ten of What Coul	ntry?
th will	al	10311 Angora Dr				623		1.0.10		U.S.	A. I4. Race - Americ	an Indian
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or tems 23a or 28a-1 show event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decede If Yes, speci	ent of H rfy Cuba	ispanic Orig in, Mexican	gin ? (Speci i, Puerto Ri	fy Yes or No- can, etc.)	'	Black, White,	
or it	by Fu	1 Never Married 2 XMarried 3 Widowed 4 Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		1   Yes 2	No No	Specify:				Specify: B1	.ack
hour:	d be	15. Decedent's		16a, Dece	dent's Usual	I Occup	ation			16b. Kir	nd of Business/In	dustry
n 72	Completed	(Specify only highest g	rade completed)	(Give	kind of wor DO NOT us	k done i	during most	t of working				
within ene. then	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Hous	ewife						Private	
e filed al Hygie other		17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name (	First, Middle, M	Aaiden .	Sumame)	
Aental Aental rkad c	To Be	Costello Wilson							M. Baı			
d 2 should th and Men ?7 is marks treumatic	-	19a. Informant's Name/Relationship	(Type, Print)								Town, State, Zip	
Health a tem 27 le		Lawrence Jackso	on /Husband	1031	1 Ango	ora	Drive		7.0		yland 2	
of Healt Item 2		20a. Method of Disposition		Place of Disp cemetery, cre	osition (Name	ne of ther plac		Da			cation - City or T	
Page lent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Special Control C		surrec	tion (	Ceme	. 4	/22/2	004	Clin	ton,Mar	yland
permit. Pages 1 Department of h Importent: If Ite any injury or ot		21. Signature of Funeral Service Lic	ensee		2. Name and			.1 . D	. Jenk:	ins r. M	Funeral Maryland	Home 20785
		23a. Part1. Enter the disease or co	implications that caused the de									Approximate Interval Between
		shock, or heart failure. List on tmmediate Cause (Final	ly one cause on each line.									Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Pulmonar		la							
Examiner			Cardiomy									
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od d ansit	Examiner	Cause (Disease or injury that initiated events	. Pulmonar	у Нуре	rtensi	on_						
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Exa	resulting in death) Last	Due to (or as a conse	equence of):								
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tifica ng ph as th	Physician/Med	IE EENALE.		-				_				
wrequires that the death cer been signed by the attendin should be detached for use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	□Ectopic pr		y			1	23d. Date of deliv Month	rery Day Year
deal ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown	death 5	Other (sp	ecify) _						
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es th igned	ρ	Part II. Other significant condition	s contributing to death out not in	esulting in the	undenying c	ause gr	remmerant		1 🗆 Y			bably 4 Unknow
equir en si ould	ted					····					<u>,                                     </u>	
he law requires t e has been signe age 2 should be	Completed								24a. Was a autops perfor	sy	24b. Were aut prior to co death?	opsy findings availab ompletion of cause of
The trate has page	LO.								1 Yes			2 <b>∑</b> No
sician: The certificate irector, pag	Be (	25. Was case referred to medical examiner?				0.1		e of Death	(Check onl or	10		
Physician: r this certific rral director,	10	1 ☐ Yes 2X No		☐ ER/Outpati		J^					6 ☐Other (Spec	ify)
		27. Manner of Death  1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		28c. Inju Wo			Bd. Describe h	ow intur	y occurred	
ending sath. or: After he funer	Certification:	2 Accident investige			М		] Yes 2 [		Pé Lagation /C	troot an	d Number of Pur	ral Route Number,
f or Attending after death. Director: Afte	tiff	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		: home, farm, : :cify)	street, factory	y, office		4	City or Tow			rai nobie Ngriber,
To the Hospital or Attendathin 24 hours after death To the Funeral Director:	al Cer	29a. Certifier 1 🖰 Certifying	Physician: To the best of my k	nowledge, de	ath occurred	at the t	ime, date a	nd place, as	nd due to the o	ause(s)	and manner as	stated.
ne Ho ne Fu ne Fu	edical	(Check only 2 Medicel E	and manner stated.		investigation	i, iii iiiy	opinion, de					
To the To the Comp	M	29b. Signature and title of certifier	11871	71	290	c. Licen	se number	1 4	4	29d. Da	te signed (Month	, Day, Year)
1	1	1	wo /	1/1	X	DE	SH &	60		4	-14-0	14
1 11		30. Name and address of person w	ho completed cause of death (I	tem 23a) (Typ	e, Print)							
1	/	Oleg Shpak M.D.	9740 Annapoli	s Rd #	210 I	Lanh	am, M	ary1a	nd 207	06		
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature								

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar		Maryland	/ Depa	rtment	of H	ealth a	and M			200		45	41
	Physicia /Medic	an :al	Decedent's Name (First, Middle     John Leo Ke11     A. Facility Name (If not institution,	Ly	harl		4h City	Town or	Location	of Death	2. Date of Do Month April	19, Day	2004 County of	ear 6	:45	еатп Ам
*	Examin	er	9508 Culver		) Jer			sing		Ji Dealli			_	omery		
	Funeral		5. Social Security Number		. Age (In yrs. last			1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di June 2.			. Birthplace (		-oreign
	Director		577-24-2163 Usual Residence of Decedent		80	Yrs.					June 2.	1, 192	23	New Y	ork	
	aryland show	'n	10a. State 10b. County		10c. City, T							-			side City	
	the N 28a-f	rect	Maryland Montgo	omery	Ken	singt	on 10f. Zip	Code			1	10g. Citiz	en of Wha	at Country?		
	h with 23a or	al Di	9508 Culver S	treet			20	895				US	A			
20	rs after deal	by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Marri 3 □ Widowed 4 □ Divorced	Armed Ford	P □ No		Vas Deced f Yes, spec I □ Yes 2		spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)		Black,	American In White, etc. Vhite	dian,	
0000-01717	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or Items 23a or 28a-f show event, I're M. dical Ex. nit er must be notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1-4)	1	(Give life. L	lent's Usua kind of wor DO NOT us	k done d	urina mos	t of work	ing			ness/Industry	,	
N	filed w Hygier other ti		17. Father's Name (First, Middle, I	5+ (ast)		Atto	rney		18, Mothe	er's Name	e (First, Middle	La:			-	
_	ould be Mental arked o	To Be	Richard L. Ha							Jen						
Maryland	2 should be filed within and Mental Hygiene. Ia marked other than aumatic event, II's M.		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	er or Rur	al Route Numb	er, City or	Town, Sta	ate, Zip Code	a)	
. ·	and 2 lealth m 27 I her fra		Jeanne O. Kel	.ly/ Wife					reet		nsingt					
Daluinore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Ia marked any injury or other traumatic events.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation		cem	etery, cren	sition <i>(Nam</i> na <i>tory</i> or of Heave	her place	9)	Apri	11 22,			ty or Town, S		
	permit. Pa Departme Important any injury		* 4 □Donation 5 □ Other (State of State		Ceme			s of Facili		2004	211/	rer S	pring,	עויו		
	Physician /Medical Examiner	Ilner	23. Part. Enter the di ease, or some control of the cause. Enter Underlying Cause (Disease or injury	a. Metas Due to (o	used the death. In the character of the	Do not enter olon ( nce of):	er the mode	e of dying	sity , such as	R)vd cardiac	W S	ilver	Spr	Appr Inter Onse Appr	M 20 roximate val Betwee et and De coxim fonth	en eath late
, 00 vo	death certificate be executed e attending physician and id for use as the burial-transit	an/Medical Examiner	that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	or as a consequent	y _	Ectopic pro	egnancy				2	3d. Date o		Ye	ar
	t the by th	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov			Other (spe				022 Did	1ahasaa		ate to the cau		
)	uires tha signed Id be de	d by	Part II. Other significant conditions Coronary Arter	-	atri but not resulti	ng in the di	idenying C	ausa giva	iii iii raiti				_	☐ Probably		
	The law requires ate has been sign page 2 should be	Completed									24a. Was auto peri 1 Yes	opsy ormed?	prio dea	re autopsy fir or to completi th? Yes 2 1	ion of cau	ailable ise of
	Physician: This certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only					
,	Phys r this ral dii	.: To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of	Injury 28	Bb. Time of	t 3 DO	Bc. Injury Work			me 5 <b>∑</b> Res 28d. Describe					
	l or Attending l after death. Director: After I in by the funer	Certification;	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	pation of be 28e. Place of	, Day Year) of Injury - At home g, etc. (Specify)	Injury e, farm, str	М	1 🗆 1	:? ∕es 2 🗆		28f. Location City or To	(Street and wn, State)	l Number	or Rural Rou	te Numbe	) <i>r</i> ,
1	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical		g Physician: To the b Examiner: On the ba and mann	sis of examination							, date and	place, and	due to the o		
	12+1	W	29b. Signature and title of certifier	n/Ju	nel.	na		D35						Month, Day,		
			30. Name and address of person Linda M. Burre	·	of death (Item 2: 2730 Ur			B1vd	#40	)O. 1	Theaton	, MD	2090	2		
	Sta Regista		31. Date filed (Month, Day, Year) APR 20		gistrar's Signatur		Spo			-, '						

			1 - For State Registrar	te of Maryland / [	Department of He Certificate of D	ealth and Me Death		ene 2 0 0 L	14542
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Young C. Kim				2. Date of Death Month 4-15-04	Day Yeer	3. Time of Death
F	Examin uneral irector		4a. Facility Name (If not institution, give street a Montgomery General E 5. Social Security Number 6. Sex 1 M M 2	lospital 7. Age (In yrs. last bir	4b. City, Town, or Olney thday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1) 2-3-19		
D	^		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location		2-3-19	19   KO	10d. Inside City Limits
the Mary	28a-f ah	Director	MD Howard  10e. Street and Number	Colum	bia		100	g. Citizen of What Co	1 ☐ Yes 2 ▼ No
th with	23a or	al Di	9242 Curtis Dr.		21045		'0	U.S.A.	outing :
JOO urs after dea	al', or items examiner m	by Funeral	1 Never Married 2 Married 1 □	s Decedent Ever in U.S. ned Forces? ]Yes 2 M No es, Give ar or Dates:	13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spec , Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify: Kol	e, etc.
III.Q. K. I.Z. I.SUUSO  be filed within 72 hours after death with the Maryland tal Hotelene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade comp.  Elementary/Secondary (0-12) Co	llege (1-4or 5+)	Decedent's Usual Occupar (Give kind of work done du- life. DO NOT use retired)	tion uring most of workin	9	Retail - Food Indus	Industry
be filed	event,	Be	17. Father's Name (First, Middle, Last) Unobtainable			18. Mother's Name	(First, Middle, Ma		
Maryla d 2 should I	7 la marke traumatic	٦	19a. Informant's Name/Relationship (Type, Pri Ki Kim - Son	nt) 19b	. Mailing Address (Street ar 18306 Founta	nd Number or Rural	Route Number, (		
Pages 1 and	y or other		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Remova  1 □ Donation 5 □ Other (Specify)	I from State	Disposition (Name of ry, crematory or other place)  Heaven	Da	ate 20	oc. Location - City or	Town, State
Department of	Importar any injur once.		21. Signature of Funeral Service Licensee	July 11 %	22. Name and Address 11800 New H	of Facility Hin	es-Rinal	di F. H.	
/M	physician and edical street in the purial-transit street prize the purial-transit street prize the prize that t	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events c.	that caused the death. Do use on each line.  Due to (or as a consequence to (or as a consequence to (or as a consequence to (or a))).	of: feritor				Approximate Interval Between Onset and Death  3 days  Many  Last your S
The law requires that the death certific	igned by the attending p be detached for use as t	Physician/Med	in the past 12 months?	es, outcome of pregnancy Live birth 2  Fetal death Pregnant at time of death Unknown	3 Ectopic pregnancy 5 Other (specify)			23d. Date of del Month	ivery Day Year
w requires that	n signed by	by	Part II. Other significant conditions contributing	ng to death but not resulting in	n the underlying cause giver	n in Part I.		cco use contribute to	the cause of death?
The law rec	cate has been si page 2 should	Completed					24a. Was an autopsy performe 1 \( \text{Yes} \) 22	d? prior to death?	topsy findings available completion of cause of
LIVISION OF THE HOSPITAL OF Attending Physician:	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospita  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury 28b. 1	itpatient 3 DOA Other	4   Nursing Hom	The state of the	ce 6 Other (Specinjury occurred	city)
DIVISION Attention after dear	To the Funeral Director: Alter completely filled in by the funer.	Certification	2 Could not be	Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28	3f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
he Hospit	he Funera pletely fille	edical	(Check only 2 Medical Examiner: Or	To the best of my knowledge the basis of examination and d manner stated.	e, death occurred at the time d/or investigation, in my opin	o, date and place, an nion, death occurred	nd due to the caus d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
To tl	To t	Σ	29b. Signature and title of certifier	20-1	29c. License	number	29d	. Date signed (Monti	n, Day, Year)
			30. Name and address of person who complete	d cause of death (Item 23a) (		Augun	Silling	Irik 15, 2	29906
gr.	Sta Registr		31. Days filed (Month, Day, Year) APR 1920	32. Registrar's Signature	Sporks	jivenue	, _ 1C UN	Sp. 1119 :11)	engines

Ī			- State Unpend Item	State of N #23a&27 p	Maryland/E per me G8	)epa Cer	rtmen 6/11/ tificate	t of H	ealth a Seath	ınd Mer	ntal Hygie	ene 1. No. 200	11.51.3
	Physicia		1. Decedent's Name (First, Middle, La Roberta Shay Kno	st)		-				2.	Date of Death Month	Day Ye	3. Time of Death ar 1:15 P M
	/Medic Examin		4a. Facility Name (If not institution, giv		r)			Town, or	Location of		YPKIL I	4c. County of E	
3	Funeral Director		5. Social Security Number 6. S		Age (In yrs. last birt	thday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. 8. Min. 00	Date of Birth (Month, Day, )	(945) 7 /. 9.	Birthplace (State or Foreign Country)
1)	show	_	Usual Residence of Decedent 10a. State 10b. County VA N. 1		10c. City, Town	or Lo	cation	Δ	fton				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the M a or 28a-f be notifie	Director	Nelson  Nelson  Toe. Street and Number  42 Towler Way				10f. Zip		229	20		D. Citizen of What	t Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hyglene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1  Yes 20 If Yes, Give Year or Dates	s? ₫No	li li	Vas Deced f Yes, spec	ify Cubar	spanic Orio	gin? (Specify , Puerto Rica	Yes or No-	14. Race - A	American Indian, Vhite, etc. White
Maryland 21215-0036	within 72 hour ine. Ihan "natural In Madical Ex	Completed	(Specify only highest gra	ducation	16a.	(Give life. L	OO NOT us	rk done d se retired;	urina most	of working		Bb. Kind of Busine	ess/Industry
land 2	ld be filed v ental Hygie ked other t ic event, tt	o Be Co	17. Father's Name (First, Middle, Last, Danny Lee Thomas	)		- Cu	S COME		18. Mother	r's Name (Fi		iden Sumame)	ir ngeney
	tnd 2 shou alth and M 127 Is mar er traumat		19a. Informant's Name/Relationship ( Brian W. Knowles/				-				oute Number, 0 A 22920	City or Town, Stat	'e, Zip Code)
Baltimore,	Pages 1 and of He ant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special		20b. Place of cometer Metrope	y, cren	natory or of	ther place		April 200	4 <sup>19</sup> A		ia, Virginia
Balt	permit. Departr Imports eny inj		21. Signature of Funeral Service Lices	1500		22 D	Name and eer P	<sup>d Addres</sup> ark	s of Facility Drive	DeVe, Gai	ol Fune thersbu	ral Home	e, 10 East 20877
8760,	Physician /Medical Examiner the prival-transit	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	c Arrythm as a consequence of as a consequence of as a consequence of	of):			, 3337 43		spinory union		Approximate Interval Batween Onset and Death
P.O. Box 68	es that the death certifici igned by the attending pl be detached for use as t	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown		2 Fetal death at time of death		Ectopic pro					23d. Date of Month	delivery Day Year
rds, P	quires Ihat the signed by ald be detacted	ed by PI	Part II. Other significant conditions (	contributing to death	but not resulting in	the ur	iderlying ca	ause give	n in Part I.				e to the cause of death?  Probably 4 □Unknown
al Reco	i: The law requir icate has been si ; page 2 should I	Completed									24a. Was an autopsy performe	prior deat	e autopsy findings available to completion of cause of 1? fes 2 No
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	25. Was case referred to medical examiner?  1 7 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident 6 Could not be determined	e 28e. Place of		ime of	M 2	8c. Injury Work 1 🗀 Y	r: 4 □ Nur	rsing Home 28d.		injury occurred et and Number o	Specify) SCI-INE  Rural Route Number,
	To the Hospital within 24 hours or to the Funeral completely filled	Medical C	29a. Certifier (Check only one)  1 Certifying PI	nysician: To the be niner: On the basis and manner	of examination and	, death d/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deati	d place, and h occurred a	due to the cau it the time, date	se(s) and manner a and place, and	r as stated. due to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier  Za Luim	uas ?	4e.		290	License	number C M	Е		Date signed (MAPRIL 16	
	•		30. Name and address of person who ZABIULLA	completed cause o	f death (Item 23a) (	Туре, І		1 Pe	enn St	reet,	Baltin	ore, Mai	cyland 21201
7	Sta Registr		31. Date filed (Month, Day, Year) APR 21 2	201	strar's Signature	9	Spo	nks	/				

		Í	1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of rtificate of			Reg. No. 20	14544
	Physici /Medio Examir	al	Decedent's Name (First, Middle, La.     Aa. Facility Name (If not institution, giv.)	Natalya street and number)	a KOPPEL	1	, or Location of De	2. Date of De Month April	Day Ye  16, 2004  4c. County of C	5:10 P M
1	Funeral		682 Ivy League La 5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. last birthday)	Rockv	r If Under 24 H		Montgo	Birthplace (State or Foreign
	Director		Usual Residence of Decedent	□ M 2 1 F	65 Yrs.	Months Day	s Hours M	Feb. 12		ussia
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ahow Josel Esandiar must be incliffed at	Irector	10a. State         10b. County           Maryland         Montg           10e. Street and Number	omery	10c. City, Town or L	ville	)		10g. Citizen of What	10d. Inside City Limits 11 Yes 2 No
	death with ms 23a o	by Funeral Director	682 Ivy League L	12. Was Decedent	Ever in U.S. 13.	Was Decedent of	20850	(Specify Yes or No	United S	merican Indian,
9000	ours after iral', or Ita		1 Never Married 27 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☑ If Yes, Give A Year or Dates:	No	If Yes, specify Cu		erto Rican, etc.)	Specify:	White, etc. white
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural; or Itams 23a or 28a-f ahow any injury or other traumatic evant, the Medical Estantial must be notified at ance.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed)  College (1-4or:	(Give	dent's Usual Occi kind of work don DO NOT use retii emaker	upation le during most of l red)	working	16b. Kind of Busine	_
Maryland 3	ould be filed Mental Hyg arkad otha atic evant,	To Be C	17. Father's Name (First, Middle, Last) Boris Musatov					Name <i>(First, Middl</i> e ia Kisina	Maiden Sumame)	
	and 2 sho ealth and m 27 la m		19a. Informant's Name/Relationship ( Alexander Koppel,		682	vy Leagi	ue Lane,	Rockvill	er, City or Town, State e, MD 208	e, <i>Zip</i> Code) 850
Baltimore,	Pages 1 ment of H tant: If ital jury or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  `4 □ Donation △5 □ Other (Specif	0	20b. Place of Disposementary, cre Metropoli		1	/20/04	20c. Location - City  Alexandria	
Ball	permit Depart Import any in		21. Signature of Foneral Service Licer 23a. Part 1. Enter the disease, or com		To		y Hebréw	Funeral		20012
	rnysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. LUK	d the death. Do not en	er the mode of dy	ying, süch ás card	iac of respiratory a	rrest,	pproximate Interval Batween Onset and Death
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
68760,	ficate be e physiciar s the buri	dical	(	d						
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnan Other (specify)	cy		23d. Date of Month	delivery Day Year
Δ.	w requires that been signed b should be deta		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause g	given in Part I.	23e. Did t		e to the cause of death?  Probably 4 Unknown
Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed							an 24b. Were prior death	
Vita	Phyaician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:				eath (Check only o	ne)	
of	ding Phys h. After this funeral di	tlon: To	1 Yes 2 No  27. Manner of Death  Natural 5 Pending  Accident investigation	28a. Date of Inju	ry 28b. Time o	f 28c. Inj			dence 6 Other (S	pecify)
Division	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At home, farm, sti c. (Specify)			28f. Location (S City or Tox		Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	edical (	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	n occurred at the vestigation, in my	time, date and pla opinion, death or	ice, and due to the courred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier  Murup	$\supset$			rse number 1823		29d. Date signed (Md 4/16/04	* ' '
	Ś		30. Name and address of person who		leath (Item 23a) (Type,	Print) Irch St	Surte	602	ROCKUILL	'e MD 2085]
,	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 20	32. Registr	ar's Signature	Spark	2			

			1 - For State Registrar		Maryland / Dep <i>Ce</i>	artment of rtificate of			Reg. No. 200	
н	Physici	an	Decedent's Name (First, Middle, La		VOITHED.			2. Date of D Month	Day Year	
,	/Medi Examir		4a. Facility Name (If not institution, gir	Sally I		4b. City. Town	n, or Location of	April	15, 2004 4c. County of De	8:25 P M
	Exami	iei	Suburban Hospital			Bethe			Montgo	
	Funeral		· ·	Sex 7. 1 □ M 2 🔏 F	Age (In yrs. last birthday)	If Under 1 Ye Months Da		4 Hrs. 8. Date of B Min. (Month, L		rthplace (State or Foreign country)
	Director		303-34-99/6	1 L M 2 LØLF	74 Yrs.	Michiais	93 110013	Dec.	3, 1929 Wa	shington, DC
	and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	Mary -fsh	ţō	Maryland Monte	omery	T.	Bethesda	1			1 ☐ Yes 2 🛣 No
	r 28a	rec	10e. Street and Number	omer y		10f. Zip Cod			10g. Citizen of What C	country?
	23e c	alD	7704 Sebago Road				20817		United St	ates
	r dea tams	Funeral Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origi Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Race - Am Black, Wh	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2] If Yes, Give Year or Date	X) No	1 ☐ Yes 2 💢 I			Specify: W	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23e or 28a-f show ant, the Medical Examinar must be notified at	edk	15. Decedent's E		16a, Dece	dent's Usual Oc	cupation		16b. Kind of Busines	s/Industry
215	nin 72 In "na Medi	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4)	(Give	kind of work do DO NOT use re	ne during most o tired)	of working		,
21	artha	Completed	Liomany/occordary (o 12)	4		emaker			Own Hor	ne
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las.	•					e, Maiden Sumame)	
<u>y</u>	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic evant, Its Ms	은	Joseph Albertson					ice Meyer:		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. itiam 27 is marked other than "natural", or itams 23e or 28e-f show other traumatic event. The Medical Examinar must be notified at		19a. Informant's Name/Relationship Milton Kovner, Hu					or Rural Route Num. ethesda. 1	ber, City or Town, State, MD 20817	Zip Code)
	as 1 and 2 of Health I itam 27 I		20a. Method of Disposition		20b. Place of Dispo	osition (Name of			20c. Location - City o	r Town State
Baltimore,	permit. Pages 1 Department of H Importent: If its any injury or ot		1 ∑Burial 2 ☐ Cremation 3 [ '4 ☐ Donation 5 ☐ Other (Speci		ite cemetery, cre	matory or other	place) U	4/19/04	1	
Ē	artme orten injuri		21. Signature of Eureral Service Los		Garden of				Clarksburg	3, MD
Ba	Dep Imp				T	Corchins	ky Hebr	ew Funeral	L Home	00010
			23a. Part T. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	pplications that cau one cause on eac	sed the death. Do not en	ter the mode of	dying, such as ca	NW Wast ardiac or respiratory	arrest, DC	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. Pneumo Due to (or	onia as a consequence of):					1 Week
8760,	_	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of): as a consequence of):					
P.O. Box 68	the death certific by the attending pached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal death 3[ t at time of death 5[	□Ectopic pregna □ Other (specify,			23d. Date of de Month	llivery Day Year
Records, F	quires that en signed t uld be det	by	Part II. Other significant conditions End-stage liver		h but not resulting in the u	nderlying cause	given in Part I.		tobacco use contribute t Yes 2 XNo 3 ☐ P	
000	e law requ has been je 2 shouk	Completed	Gastrointestinal	bleed				24a. Wa		utopsy findings available completion of cause of
Ä	The ate his page	mo;	Coagulopathy						ormed? death?	_
Vital	sician: The certificate his rector, page	Bec	25. Was case referred to medical examiner?				26. Place o	of Death (Check only		
of V	Physic this co	2	1 ☐ Yes 21 No		atient 2 ER/Outpatier	IL SI DOA			idence 6 Other (Spe	ecify)
	After	atlon:	27. Manner of Death 1		njury 28b. Time o Day Year) Injury		njury at Vork? ☐ Yes 2 ☐ No		how injury occurred	
Division	al or Attand after death   Diractor: , d in by the f	Certification:	3 Suicide 6 Could not to determined	289. Flace of	Injury - At home, farm, streetc. (Specify)	reet, factory, office	Ce	28f. Location City or To	(Street and Number or Rown, State)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funaral Dirac completely filled in by	Medical C	29a. Certifier 1 XCertifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis and manner	est of my knowledge, deat s of examination and/or in stated.	h occurred at the vestigation, in m	s time, date and by opinion, death	place, and due to the occurred at the time	cause(s) and manner a , date and place, and du	s stated. e to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier				ense number		29d. Date signed (Mon	th, Day, Year)
	6		1 Start	MD		D00	60117		April 16,2	004
	>		30. Name and address of person who	completed cause of	of death (Item 23a) (Type,	Print)			T-15-1	
2			Eric J. Park, M.			ter Dr.	, Rockv	ille, MD	20850	
1	Sta Regist		31. Date filed (Month, Day, Year) APR 19 2	004 32. R/9	istrar's Signature	Span	les			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#10eperINF, 4/20/04, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month April 13 2004 Louis George Kontsis 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MOntgomery General Hospital 01ney Montgomery Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min. 1GM 2□F Months Hours Yrs. 579-36-6550 June 8, 1931 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland Montgomery Wheaton 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code <del>13101</del> Estelle Road 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes. 2 □ No If Yes. Give Year or Dates: 1951–55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Accounts Payable Pharmacy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Kontsis George Louis Kontsis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anastasia Kontsis - wife 13103 Estelle Road, Wheaton, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 4-16-2004 Silver Spring, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Single Truneral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Av., Silver Spring, MD 20904 23a. Part. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Lection new Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consid ewbins acral Due to (or as a consequence of): Sind IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? ai line Heart 1 ☐ Yes 2 XNo 3 Probably 4 Unknown ofe wishow 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 K Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

**Examiner** and I-transit The law requires that the death certificate be executed the attending physician a ned for use as the burial-Box 68760, as the Records, P.O. ğ Jas page 2 ate Division of Vital To the Hospital or Attending Physician: within 24 hours after death. certific director this After within 24 hours after death To the Funerel Director: à

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

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Items 23a

nit. Pages I and 2 should be filed within 72 hours after death aritment of Health and Mental Hygiene.
ortant: If Item 27 is marked other than "natural", or Items 23t injury, or other traumatic event, the Medical Exemples traus.

Depart Import sny inj once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Completed by Funeral Director

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Examine

Physician/Medicai

Completed

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Certification:

Medical

with the Maryland

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Menner of D ath 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onli

29b. Signature

29c. License number 29d, Date signed (Month, Day, Year)

Seltresda

053691

rslud

s of person who completed cause of death (Item 23a) (Type, Print) 320 REDDY MO

5

31. Date filed (Month, Day, Year)

32. Registrar's Signature

maker

State Registrar Devinocorry

Registrar

			1 - State of Man	-	epartmer Certifica		Death	Reg.	ne <sub>No.</sub> 2001	4 14548
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     Kishore Kotagiri      A. Facility Name (If not institution, give street and number)		4b. City	Town, or		2. Date of Death Month April 5,	Day Year 2004 4c. County of Dea	3. Time of Death  8:48 A
	Funeral Director	. 4	10 M 2 T F	In yrs. last birth	day) If Unde	r 1 Year Days	Spring If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, Ye	Montgomer (Control of the sear) 9. Bir (Control of the sear) 1949 Ind	thplace (State or Foreign ountry)
	D	tor	Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town Silver			Tive	50. 21,	1949   ING	10d. Inside City Limits 1 Y Yes 2 □ No
036	permit. Pages 1 and 2 should be itled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ORGE.	I by Funeral Director	1705 January Dr. Apt. 102  11. Marital Status  1 Never Married 2 Married 3 Widowed ***Divorced 12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.			)4 spanic Origin? (Spec n, Mexican, Puerto Ri Specify:		USA  14. Race - Ame Black, White Specify:	orican Indian,
121215-0	led within 72 ho ygiene. her then "natu it, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  4Yrs.		Decedent's Usu Give kind of w life. DO NOT u ail Sa	ork done d se retired	during most of working )  Ianager		Sales	Industry
aryland	should be fit and Mental H s marked oth	To Be	17. Father's Name (First, Middle, Last)  Venkat Narayan Kotagiri  19a. Informant's Name/Relationship (Туре, Print)	19b. I	Mailing Addres	s (Street a	18. Mother's Name ( Sarah Alei and Number or Rural (	ti		Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health 4 Importent: If item 27 I any injury or other tre 2002.		I Dedital 2 Chemation 3 Diversional non-state	20b. Place of Cometery	Disposition (Na crematory or Park C 22. Name a	me of other plac Cmeat nd Addres	ory 04/16	/2004 Bas-Rinald:	altimore, Funeral	Town, State
68760,	Physician /Medical Examiner burian-travel sthe purial-travel	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the cause). Due to (or as a condition of the cause).	sity consequence of p Apnea consequence of	): a with I		g, such as cardiac or			Approximate Interval Between Onset and Death
9/04 5. Box	the death certifica y the attending pt ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	Fetal death	3 □Ectopic p 5 □ Other (s				23d. Date of del Month	ivery Day Year
ia Price "t Records, P.C	law requires that the as been signed by th 2 should be detache	Ď	Part II. Other significant conditions contributing to death but r	not resulting in t	the underlying	ause give	on in Part I.	1 ☐ Yes	2 😾 No 3 🗆 Pr	the cause of death?
Coorgia (A. A. A. Vital Rec	inn: The law rtificate has t ttor, page 2 s	Se Completed	25. Was case referred to medical				26. Place of Death (	24a. Was an autopsy performed 1 Yes 24	prior to death?	topsy findings available completion of cause of
Sion o	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification: To B	27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not be	28b. Tir (e <i>ar</i> ) Inji	me of ury M	28c. Injury Work 1 🗆 `	at 28 // Os 2 No	d. Describe how in		
Divio	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined 200. Place of might building, etc. (c)  29a. Certifier (Check only 2 Medical Examiner: On the basis of ex	Specify) my knowledge,	death occurred	at the tim	e, date and place, an	City or Town, Si	e(s) and manner as	stated.
•	To the H within 24 To the Fi complete	Medical	29b. Signature and fittle of certifier	d.	29	c. License	number	29d.	Date signed (Monti	n, Day, Year)
25			30. Name and address of person who completed cause of deat Thuan-Hoa Nguyen, M.D. 1220	n (non 23a) (T 1 Plum	ype, Print) Orchard	Dr.	Silver Sp	oring, MI	20904	
	Sta Registr		31. Date filed (Month, Day, Year)  APR 15 2004  32. Registrar's	Signature	1 de	med 2	/			

State of Maryland / Department of Health and Mental Hygiene 16569 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April 2004 Sherri L. Knight **Physician** 9 7:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Annapolis Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, NOV 1 9. Birthplace (State or Foreign Country)
D • C 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 40 1963 212-84-6065 Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Maryland Anne Arundel Annapolis 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 1310 McKinley St. 21403 USA death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or iten any injury or other traumatic event, the Medicul Exard any 2018. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anne Arundel Co. College (1-4or 5+) Elementary/Secondary (0-12) Housing Counselor Community Action 12th 3yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Knight EDith Jones 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Knight (Mother) 1220 Madison St. Annapolis, Md. 21403 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Be serges trenated environmental 1 20c. Location - City or Town, State Park 4-14-04 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Wm. Reese & Sons Mortuary West St. Annapolis, Larry G. Less MOOY83 821 Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Sepsis hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certiticate be executed Causs (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2\No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 1 ☐ Yes Z ۵ patient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 005 336 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medica tarkway 2001 SNOW 31. Date filed (Month, Day, Year) egistrar's Signature State APR 1 3 2004 Registrar

		For State Registrar	State of	f Marylar		artment of		nd Mer		ene . No. 201	16		550
Physicia	an	1. Decedent's Name (First, Middle Marvin F. Ki	•						Date of Death Month Or.	Day Y	eer 004	3. Time of 7:30	
/Medic Examin	100	4a. Facility Name (If not institution,	give street and num	nber)			n, or Location of		P1 •	4c. County of	Death	Arund	
Funeral Director		5. Social Security Number 193–28–2874		7. Age (In yrs. 67	last birthday) Yrs.	if Under 1 Ye Months Da	ar If Under 2	Min.	Date of Birth (Month, Day, Y ept. 26	ear) 9	. Birthpi	place (State on try) nsylva	or Foreign
death with the Maryland ms 23a or 28a-f show Linest be troubled at	tor	Usuel Residence of Decedent  10a. State 10b. County  MD Anne	Arundel		ty, Town or Lo	cation					11	0d. Inside C	ity Limits
with the	Il Director	10e. Street and Number 707 Hillcrest D	rive	- l		10f. Zip Cod	012		10g	. Citizen of Wha	it Coun	itry?	
P 2 2	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Marri 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Types If Yes, Giv. Year or Da	rces? 2 □ No 195	3-	Was Decedent of Yes, specify C		in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - Black, Specify:	White,		
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. 7 is marked other then "natural", or traumatic event, the Medical Extra	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1		16a. Dece (Give life.	dent's Usual Oc kind of work do DO NOT use rei	ne during most ired)			b. Kind of Busin			
Viand Z ould be filed v Mental Hygis arked other t atic event, th	ro Be Co	12 17. Father's Name (First, Middle, I Thomas Kindred			Comm	unicati	18. Mother	's Name (Fi		Arinc R iden Surmame) i	adio	<b>D</b>	
C = W -		19a. Informant's Name/Relationsh Bonnie Kindred/								City or Town, Sta MD 2101		Code)	
IMOFE Pages 1 ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp		State	Vetera	esition (Name of matory or other p ans ceme	etery   P	April 2004	10	c. Location - Cit Crownsvi			
Bait permit. Departitions any inj		21. Signature of Funeral Service I	FAIL			Name and Ad Franco 5 Gov.				na Park na Park	Fur MI	neral 2114	Home 16
Physician /Medical Examiner		23a. Part. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a. Met	aused the deal ech line Tratt	ic Ca	er the mode of	5/	7/	and k	Pectum		Approximal Interval Bet Onset and	tween
BOX 68/60, death certificate be executed e attending physician and infor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	or as a consec									
LO. BOX 68.  In the death certification by the attending ptrached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		inth 2 □Feta ant at time of c	aldeath 3□	Ectopic pregna Other (specify				23d. Date o Month		,	Year
S, F es that gned be de	þ	Part II. Other significant conditio	ns contributing to de	eath but not res	sulting in the u	nderlying cause	given in Part I.		23e. Did tobac	cco use contribu	ite Io th		death? Unknown
The The ate h	Completed								24a. Was an autopsy performe	g? prio	r to con th?	psy findings npletion of c 2 No	available cause of
DIVISION OF VITAI IN To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  Natural 5 Pendin.  Accident Pressing	28a. Date o (Monte	npatient 2 of Injury h, Day Year)	ER/Outpatier 28b. Time o Injury	28c. li	Other	sing Home 28d.	_	e 6 Other (	Specify	)	
DIVISIO  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	nod 200. Flace	of Injury · At h	ome, farm, str fy)	eet, factory, offi	СӨ	28f.	Location (Stree City or Town, S	et and Number o State)	r Rural	Route Num	ber,
the Hospi in 24 hour the Funer npletely fill	Medicai	(Check only 2 Medical I	g Physician: To the Examiner: On the ba and mann	asis of examina	wledge Jean ation and/or in	vestigation, in m	y opinion, deatl	diplace, and hiocourred a	it the time, date	and place, and	due to	the cause(s	5)
To To	2	29b. Signature and tale of certifier	P. Ced	Gene	- W	10-	col 85	566	29d	Dale signed (A	ionth, L	) ay, Year)	
00		30 Name an address of person	MANO	W()	1	Print)	wiref	Coe	serve	AN	NA	2/3	MID
Sta Registr		31. Date filed (Month, Day, Year)	9 2004	eg (frar's Signa	aiule de	And I					•		

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of <i>rtificate o</i>	Health a f Death	nd Mental Hy	/giene2 ()	04 1	4551
	Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of D		Year	me of Death
	/Medio		John F. Klar, Ji					Apr.		2004 6:	10 p м
	Examir	ner	4a. Facility Name (If not institution, given Anne Arundel Median Records)	· ·			, or Location of Annapol		4c. County	of Death Ne Arundo	<b>~1</b>
	Funeral				e (In yrs. last birthday)						
	Funeral Director			1⊠M 2□F	69 Yrs.	Months Day	s Hours	Min. (Month, D	ay, Year) 11, 1934	9. Birthplace (S. Country)	OK
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo					1	
	faryla show	ō		Arundel	Toc. City, Town or Et	ocation	Arno	NA.			de City Limits Yes 2√2 No
	the N	Director	10e. Street and Number	<u>uidei</u>		10f. Zip Code		nia –	10g. Citizen of V		A-
	3a or	i Di	1131 Asquith Driv	<i>7</i> e			1012			JSA	
	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-1 show its Madical Examinar must be rollined at	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent o	f Hispanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Rac	e - American India	an,
36	or its	by Fu	1 ☐ Never Married 2 ☑ Married	1 ☑ Yes 2 ☐ I If Yes, Give	<sup>№</sup> 1958–	1 ☐ Yes 2 🛣 N		7 40110 7 110411, 010-7	Specify	TiTh i to	
ö	hours tural	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	1961	dent's Usual Occ	rupation			usiness/Industry	
15	n "na n "na	piet	(Specify only highest gr	ade completed)	(Give	kind of work dor DO NOT use reti	ne during most ired)	of working			
21215-0036	力高生	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Consult	ant		Seli	f-Employe	∍d
nd	重工者に	Be	17. Father's Name (First, Middle, Last					's Name (First, Middle		1e)	
Z	2 should be and Mental Is markad aumatic ev	٦ ک	John F. Klar, Si		121			nalee Simme			
Maryland	ges 1 and 2 should t of Health and Men If itam 27 Is marks or other traumatic		19a. Informant's Name/Relationship ( Barbara N. Klar)					or Rural Route Numb ve, Arnold		State, Zip Code) 21012	
je,	of Health itam 27 other tr		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other p	Maga) -	Date	20c. Location -	City or Town, Sta	te
Ë	Pages nent of int: If it	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special			Cremator		Apr. 19, 2004	Baltimo	ore, MD	
Baltimore,	permit. Pages Department of I Important: If its any Injury or of		21. Signature of Euneral Service Lice	nsge //	22	2. Name and Add	ress of Facility		orna Darl	k Funora	1 Home
_	8258		Memil	111	49	95 Gov.	Ritchie	Hwy, Seve	erna Parl	k, MD 2	1146
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each li	the death. Do not ent	ter the mode of d	ying, such as c	ardiac or respiratory a	arrest,		kimate Il Between and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ume	okec On	cephale	portn	4		4,3	5 days
	Examiner		1	Due to (or as	a consequence of):	La Don	han 1	andrac a		414	Erla de
		Jer.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of).	Julia	1111 (	grance w	Ous	710	July 3
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. 15d4	emic Co	adiom	MORE	My		260	<i>slais</i>
90,	sate be executed they sician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):	,	7 //			()	
8760,	death certificate be executed e attending physician and od for use as the burial-transi	dicai		_ d						-	
9 X	leath certific attending p I for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Det	a of dalisans	
Вох	atter d for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death 3	Ectopic pregnar Other (specify)			Mor	e of delivery nth Day	Year
Ö.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown							
S, P	Se US	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause of	given in Part I.	23e. Did 1	tobacco use contr	ibute to the cause	of death?
ord	w require been si should b	ted	Cerebral V	ascular (	ccident	<i>F</i>		1	Yes 2 No	3 Probably	Unknown
ec	has be	Completed	atrial 7	bullati	n			24a. Was	psy p	Vere autopsy findi prior to completion	ngs available of cause of
al H								perfo 1 ☐ Yes		leath? ☐ Yes 2☐ No	
Zi:	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check only o			
oţ	Phys er this eral di	To it	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b. Time o			sing Home 5 Resi	dence 6 Othe how injury occurre		
ion	nding ath. r: Afte e fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	y Year) Injury		lork? □Yes 2□N	0			
Division of Vital Records,	r Attandi er death ractor: A	Certification;	3 Suicide 6 Could not be determined	e 28e. Place of Inj	ury - At home, farm, str c. (Specify)	eet, factory, offic	9	28f. Location ( City or To	Street and Numbe	er or Rural Route	Number,
	Ital or A irs after ral Dirac lled in by										
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Pt (Check only one)	miner: On the basis of	of my knowledge, deat f examination and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time,	cause(s) and mar date and place, a	nner as stated. and due to the cau	Ise(s)
	o the o the omple	Med	29b. Signature and title of certifier	and manner sta	ated.	29c. Lice	nse number		29d. Date signed	(Month, Day, Yea	ar)
•	H 3 H 0		1 150.11		3	D41			auli	8/04	
			30. Name and address of person who	completed cause of d	leath (item 23a) (Type,		.,,,,,		07/1	0107	
2			2002 Medica	2 parkwo	my Svite	500 0	innapo	olis MO			
	Sta Registr		31. Date filed (Month, Day, Year)	.2004 32. Registra	ar's Signature	have .	/				
	riegisti	ar	MAL TA	TOO I		William Tolking					

			For State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygier	- Z H H & + 1 & 5 5 2
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Roger William Kraft		2. Date of Death	Day Year 3. Time of Death
	Examir		4e. Facility Name (If not institution, give street and number)  St. Mary's Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Dea  Leonardtown  If Under 1 Year   If Under 24 Hr.	s. 8. Date of Birth	4c. County of Death  St. Mary's  9. Birtholace (State or Foreign
	Director		213-40-9260	Months Days Hours Min		1942 Washington, D.
	r 28a-f ehow	Director	10a. State 10b. County 10c. City, Town or L  Maryland St. Mary's Piney Po  10e. Street and Number		10g. (	10d. Inside City Limits 1 ☐ Yes 2 ▼No  Citizen of What Country?
9200	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "netural", or Items 23a or 28s-f show or other traumatic event, the Medical Exertimes the notified at	by Funeral	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  Agned Forces 7 1967 — If Yes, Give Year or Dates: 1970	20674  Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1 □ Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	U.S.A.  14. Race · American Indian, Black, White, etc.  Specify: White
21215-0036	within 72 h ane. than "netu	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)  CURITY Officer	orking	Kind of Business/Industry  Art Gallery
land 2	ild be filed lental Hygid ked other ic event, II	To Be Co	17. Father's Name (First, Middle, Last)  Norman Kraft	18. Mother's Na	ame (First, Middle, Maid d Swift	
re, Maryland	s 1 and 2 shou of Health and M item 27 le mar other traumat		19a. Informant's Name/Relationship (Type, Print)  19b. Mail Mildred Kraft / Mother  20a. Method of Disposition  20b. Place of Disposition	ling Address (Street and Number or F	imbers, Mar	y or Town, State, Zip Code)  yland 20690  Location - City or Town, Stete
Baltimore,	permit. Pages Department of I Important: If its eny injury or o		14 Donation 5 Other (Specify)  21. Signature of Funeral Service Ucensee	coln Cemetery Apr 22. Name and Address of Facility B	rinsfield F	Brentwood, Maryland Funeral Home, P.A. Itown, Maryland 20650
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)			Approximate Intervat Between Onset and Death
8760,	eath certificate be executed attending physicien and for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	y Artery tive Hea	Difer vt fan	nse Enre
.O. Box 68	The law requires that the death certificate has been signed by the attending place age? should be detached for use as to	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
s, P	quires that I n signed by uid be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacci 1 ☐ Yes	o use contribute to the cause of death? 2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( \frac{\mathbf{K}}{\text{Unknown}} \)
Division of Vital Record		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 🛣 No
Vita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:	Othors	eath (Check only one)	TO THE TOTAL OF THE PARTY OF TH
on of	F = E	tion; To	27. Manner of Death 1 Note of	ent 3 DOA 4 Nursing	Home 5 Residence 28d. Describe how in	
Divisi	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or within 24 hours affer to the Funerel Directions occupietely filled in I	edicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal carrier on the basis of examination and/or and manner stated.	ith occurred at the time, date and place nvestigation, in my opinion, death occurred.	e, and due to the cause surred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
1		W	29b. Signature and title of certifier	29c. License number	634 290.0	Date signed (Month, Day, Year)
11	100		30. Name and address person who completed cause of death (Item 23a) (Type Adinath A. Patil, M.D. 24035 Three	Notch Road Holly	wood Maryla	and 20636
-	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	and s		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

JD			For State Registrar		State of Ma	aryiano / L	Jepai Certi	ificate of i	leaith and i Death	vientai ny	Glene Reg. No	200	Ļ	1455	53
		**************************************	Decedent's Name	(First, Middle, Las	st)					2. Date of De	ath		ar.	3. Time of De	
	Physicia /Medic		Mark	Quenti		arns						<sup>ay</sup> 2004 <sup>Ye</sup>		2231P.	М
	Examin	er	4a. Facility Name (If I	not institution, give iree Noto	_		1	4b. City, Town, or Charlot	r Location of Deatl te Hall	n		c. County of D Saint M		's	
	Funeral		5. Social Security Nu			e (In yrs. last bir		If Under 1 Year	If Under 24 Hrs.	8. Date of Bii (Month, Da				ace (State or Fo	oreign
	Director		219-15-642	29	ØM 2□F	22	Yrs.	Months Days	Hours Min.	Jan. 3	, 19			nia inia	
	lend w		Usual Residence of E	10b. County		10c. City, Tow	n or Loca	ition					10	d. Inside City L	Limits
	Mary 8-1 sh	ţor	Maryland	St. Ma	ary's		I	Mechanic	sville					1 ☐ Yes 2	<b>₽</b> No
	or 28.	Director	10e. Street and Num	per				10f. Zip Code			10g. C	itizen of What	Count	ry?	
	sath w		26255 Gard	liner Cou	12. Was Decedent	Ever in 11 S	12 W	206		poorfy Vas or No	$\overline{}$	ted St			
980	be filed within 72 hours after death with the Marylend ital Hygiene. od other than "natural", or Items 23a or 28e-f show event, the Medical Examinating to indiffed at	by Funeral	11, Marital Status 1  Never Marrie 3  Widowed 4		Armed Forces?  1  Yes 2 fif Yes, Give Year or Dates:				lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)		Black, W	Vhite, e	tc.	
2-0	72 ho	eted		15. Decedent's Ed y only highest gra		16a.	(Give kir	nt's Usual Occup	during most of wor	king	16b. F	Kind of Busine	ess/Indu	ustry	
121	within ane. than *	Completed	Elementary/Second		College (1-4or 5		lite. DC	NOT use retired	1)		E1 a	victor.	Com	structi	d
d 2	filed Hygi ther	Be Co	17. Father's Name (F	irst, Middle, Last)		ET	evat	or Techn	18. Mother's Nar	ne (First, Middle			COII	Structi	LOII
/lar	should be ind Mental marked o	To B	Michael A	anthony I	Kearns			į	Heather	Lesley	Can	neron			
Maryland 21215-0036	s man	e Î	19a. Informant's Nan	, ,					and Number or Ru						
	Health tem 27 l	1	Heather  20a. Method of Dispo		ns / Mothe	20b. Place of	255 ( Disposit	Gardiner ion (Name of tory or other plac	Court,	Mechani Date		lle, M. ocation - City			
E E	Pages lent of nt: If in		1  Burial 2 □ `4 □ Donation 5		Removal from State  /)				ıs. Apr.	22,2004	Wa1	dorf.	Mar	vland	
Baltimore,	permit. Pages Depertment of the Importent: If ite any injury or of 2009.		21. Signature of Fun						ss of Facility Br						P.A.
	80 5 5 8		Edward N.	Brinsfie					Notch R			csvill			59
			shock, or heart	failure. List only	olications that caused one cause on each li	i the death. Do i je.	not enter	the mode of dyin	g, such as cardiad	or respiratory a	rrest,		1	Approximate Interval Betwee Onset and Dea	en ath
	Pnysician /Medical		disease or condition resulting in death)		a. Due to (or a	a consequence	fair	(us							
ı	Examiner		Sequentially list cond	ditions	b										
	Bod Isit	iner	Sequentially list condificant, leading to immorause. Enter Understance (Disease of its	nediate ying	Due to (or as	a consequence	of):								
<u>,</u>	axecut n and ial-tran	Exan	that initiated events resulting in death) La		c. Due to (or as	a consequence	of):						-		
68760,	rificate be executed no physician and as the burial-transit	Aedicai Examine			. d										
			IF FEMALE:								T				
Вох	death cer e ettendin id for use	Physician/	23b. Was decedent p in the past 12 m	nonths?	23c. If yes, outcome  1 Live birth  4 Pregnant at	2 Fetal death		ctopic pregnancy Other (specify)				23d. Date of Month		y Day Yea	ır
0		hysi	1 Yes 2 Unknown	No	9□ Unknown			- (aposy)							
s, P	faw requires that the as been signed by th 2 should be detache	by P	Part II. Other signific	ant conditions o	ontributing to death b	ut not resulting in	n the und	erlying cause give	en in Part I.					cause of deat	
ecord	w requir	eted								1000000	Yes 2	44.55	] Probal	, ,	
Rec	9 - 9	Completed									psy ormed?	prior	to com	sy findings ava pletion of caus	illable se of
Vital	icien: Th	0	25. Was case referre	d to medical					26. Place of Dea		2□No one)	1 10	/es 2	2□ No	
of Vi	d is	To B	examiner? 1X Yes 2 N	0	Hospital: 1 Inpatie	ent 2 ER/Ou	tpatient	3□ DOA Oth	00	lome 5 Resi		6 <b>X</b> Other (5	Specify)	(scen	ie)
		ion:	27. Manner of Death 1 ☐ Natural	5 Pending	28a. Date of Inju (Month, Da	y Year)	Time of njury	28c. Injun Worl		28d. Describe	how inju	orland.	Sel	net	
Division	eatl or:	ficat	2 Accident 3 Suicide	investigation  6 Could not be determined	28e. Place of In	ury - At home, fa	rm, stree		Yes 2 No	28f. Location (		nd Number or	Rural	Route Number	r,
Ö	7 # i= C	Certification:	4 🗍 Homicide	30.01111103	building, et		hoa	1/		City or To		(Cue tre	NU	weent co	hood
	To the Hospitel of within 24 hours af To the Funerel D completely filled it	edical (	(Check only 2	☐ Certifying Ph ※ Medical Exam	ysicien: To the best	examination an	death o	curred at the time stigation, in my of	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s date an	s) and manner od place, and	r as stat	ted. the cause(s)	7
	To the within 2 To the complet	Med	one) 29b. Signature and ti	tle of certifier	and manner sta	1100.		29c. License	e number		29d. Da	ate signed (M	onth, D	ay, Year)	
•	40		1/	-l- 11	1 Keia			O.C.1	M.E.		Ap:	ril 16	, 20	)04	
	TO O		30. Name and address	_	completed lause of d	eath (Item 23a)	(Type, Pr	int) 111 D.	enn Stre	et Relt	imo	re. Ma	rv1:	and 212	201
			THEUDE 31. Date filed (Month	DE MIL		r's Signature		TIT P	CILL SCIE	cc, Dari	_ ш к/.	LC, FILL	-, -		
	Sta Registr		C. Date filed (World	APR 2	0 2004		10	Branks.							

			1 - For State Registrar	State of Maryland	d / Depa		lealth and I	Mental Hygi	ene	
	Di		Hegistrar  1. Decedent's Name (First, Middle, Las	51)		timoato or	Death	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic	cal	Sylvia Ki					4	17 00	17-AM
	Examin	ner	4a. Facility Name (If not institution, give	e street and number) ENEVAL HOSPIT	1-1	NI	r Location of Death	1	4c. County of De	hester
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. Is		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign country)
	Director		218-20-7169	□M 25€F 77	Yrs.	Months Days	Hours Min.	(Month, Day, ) Sept. 17	, 1926 M	aryland
pu	*		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
) Manyla	f sho	ō	MD Dorches		,	Cambri	dge			1 XYes 2 □ No
<u>ا</u>	r 28a	irec	10e. Street and Number		<del></del>	10f. Zip Code		10	g. Citizen of Whal (	Country?
d Z I Z I 3-0030 C C I I I I I I I I I I I I I I I I I	f Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28a-f show other treumatic event, the Medical Experiment must be multified at	Funeral Director	520 Glenburn Av	e.			21613		U.S.A.	
er dea	tems	unei	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
rs afte	I', or i	by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:		1 □ Yes 2) 🗷 No	Specify:		Specify:	white
2 Por 2	atura ical E	ted	15. Decedent's Ec	(ucation	16a. Dece	dent's Usual Occup	ation	king 10	6b. Kind of Busines	s/Industry
Ithin 7	nen "r e Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired		King		<b>C</b>
w peli	tygier ther th nt, th		8 17. Father's Name (First, Middle, Last)			seamstre		ne (First, Middle, Ma	garment	mig.
d be f	ental I ked ol c eve	To Be	Aubrey L. Moore					ine E.Tre		
aryic should	and M mari umati	F	19a. Informant's Name/Relationship (1		19b. Mailir	ng Address (Street		ral Route Number,		Zip Code)
and 2	n 27 is		Cheri Barnes	daughter				, Cambrid		1613
MOre Pages 1	0		20a. Method of Disposition  1 Burial 2 Cremation 3 C	Hemovai irom State		osition (Name of matory or other plac	1		Oc. Location - City of	
TITT t. Pag	rtment rtent: njury c		4 □Donation 5 □ Other (Specify					4/20/04 nomas Fune		
	Department Importent: f any injury o		21. Signatur / Ineral Service Licen	\$66				mbridge,		
			23a. Parti. Enter the disease, or companded, or heart failure. List only	plications that caused the death						Approximate Interval Between
Pi	ıysician		Immediate Cause (Final disease or condition	a. Pneumo						Onset and Death
/	Medical		resulting in dealh)	a. Due to (or as a consequ	ience of):					20045
-	kaminer	<u>.</u>	Sequentially list conditions,	b. UVOS 49 Due to (or as a consequ						50245
ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause juisease or injury	dehid	is to	0/10				5days
ou, be executed	in and jal-tra	Exai	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):	O. 7				3 404)
• 0	ysicia 1e bur	cai		d						
.O. BOX 68 the death certifical	attending physician and for use as the burial-transit	Physician/Med	IF FEMALE:							
DOX	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1☐Live birth 2☐Fetel 4☐Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
j ş	y the iched	ysic	1 ☐ Yes 2 <b>②</b> No 9 ☐ Unknown	9☐ Unknown	aur 3	_ Cirier (Specify)				
Ords, P	signed by Id be detacl	by Pł	Part II. Other significant conditions c	ontributing to death but not resu	ilting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
COLOS w requires	been sig should b	ted	Dementia					1 ☐ Yes	2 <b>12</b> No 3 □ F	Probably 4 Unknown
§ G		Completed	Arthritis					24a. Was an autopsy	/ prior to	utopsy findings available completion of cause of
r e	cate h	Sol						performe 1 ☐ Yes 2	death? DNo 1 ☐ Ye	s 2□No
OT VITAL Physician:	n. After this certificate has t funeral director, page 2 s	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	ED/Outerties	Oth		th (Check only one)		
	rthis ral d		27. Marrier of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	y at	ome 5 Residen 28d. Describe how		өспу)
VISION	death. ctor: Afte y the fun	atio	1 ✓ Natural 5 ☐ Pending investigation		Injury	M 1 □	Yes 2 □No			
UIVISION For Attending	ter deat irector: irector:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		me, farm, str	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
Hospitel	urs af erel D iiled ir		CO. C. William A. F. A. Anthrica Ch	veisions To the book of our book				and due to the co-		
Hos	CA 00 00	Medical		ysicien: To the best of my knowniner: On the basis of examinational and manner stated.						
To the	within To the	₩	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Mor	nth, Day, Year)
,			Paner	n		40	0599	73	4/17/0	4
2			30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	0 5+ 1	ambri d	're me	21613
		ata	31. Date filed (Month, DA) Real (	2004 32. Refustrar's Signat	ture &	I divon	, -	ori Uria	g, me	121415
	Sta Registi	ate rar	13. 15. Lea	LUUT Selece	D.	GOOD !				

		4	1 - For State Registrar	State of M	arylan	id / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a Death			Reg. No		
	Physici /Medic		1. Decedent's Name (First, Middle, Las. Kate Jacobs Kane	1)							Month	Da	ay Year 2004	3. Time of Death 10:45 p <sup>M</sup>
2	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death			c. County of Dea	
	Э, П		Manor Care Health					iesda		0410			ontgomer	
	Funeral Director		370-32-4023	7. Ag	94	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	Date of Bir (Month, Da pril 1	ay, Year	1909 Aus	thplace (State or Foreign ountry) Stralia
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	<del></del>						10d. Inside City Limits
	Mary f ehc	to	MD Montgome	rv	Bet	hesda								1 ☐ Yes 2 X No
	r 28a	Director	10e. Street and Number			110044	10f. Zip	Code				10g. C	itizen of What C	ountry?
	h with	a D	5923 Onondaga Roa	d			2	0816				USA		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Evaluate roust be mailtied at ance.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates:			Was Deced f Yes, spec 1  Yes		spanic Ori n, Mexican Specify:		fy Yes or No can, etc.)	0-	14. Race - Ame Black, Whi Specify: Wh	te, etc.
Ď	2 ho	ted	15. Decedent's Ed (Specify only highest grad			16a. Deced	dent's Usua	al Occupa	ation	t of working	,	16b. i	Kind of Business	/Industry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)				)	t of working				
7	ed wi ygien ygien ygien th	Completed		5+		Home	emake	r	40.11-45	d- N (	e: -		n Home	
Maryland 21215-0036	should be fill and Mental H ind Mental H is marked ott umatic even	To Be	17. Father's Name (First, Middle, Last) Philip Jacobs							s Jac	First, Middle obs	o, Maidei	n Sumame)	
a	2 she and and is my		19a. Informant's Name/Relationship (7										or Town, State,	
	and fealth m 27 har ti		Nancy Kane Newman	- Daught		_				ve Fa.			h, VA 2	
0	ges 1 It of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2  ☐ Cremation 3 ☐			Place of Dispo			,				ocation - City or	
Baltimore,	t. Pa rtmen rtant:		21. Signature of Conera Service	)	Me	tropoli					6/04		exandri.	
Ba	Dep.		X/ T/T/ III		1000								ral Hom	e
7			23a. Part1. Exter the disease, or comp	ications that cause		180 748			-				, VA	Approximate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Heart	Fail	ure								Interval Between Onset and Death Sudden
ł,	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. Corona  Due to (or as	ary A	rtery	Disea	ise				12		01d
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury			lerosi	c							01d
8760,	icate be executed physician and s the burial-transit	ical Examiner	that initiated events resulting in death) Last	Due to (or as			J							Old
.O. Box 61	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	ıl death 3 ☐	Ectopic pr						23d. Date of de Month	livery Day Year
s, P	quires that n signed b uld be deta	by	Part II. Other significant conditions of Bilateral Pneumo	•	out not res	sulting in the u	nderlying c	ause give	en in Part I.			tobacco Yes 2	_	o the cause of death?
al Record	ysician: The law requires that the is certificate has been signed by the director, page 2 should be detached.	Completed									24a. Was auto perfo 1 Yes		prior to death?	utopsy findings available completion of cause of
Vital	Physician: r this certificantal director.	Be	25. Was case referred to medical examiner?	Hospital:				Other		of Death (	Check only	one)		
of	Physi this o	2	TE THE ZAINO	1 Unpati		ER/Outpatien			4 X IAU			_	6 Other (Spe	ecify)
	fte ne	atlon	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		ly Year)	28b. Time of Injury	M	8c. Injury Work 1 🔲	rat ⟨? Yes 2□		d. Describe	now inju	ary occurred	
Division	To the Hospital or Attendiduith 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury · At he tc. (Specif	ome, farm, str fy)	eet, factory	, office		28	f. Location ( City or To			ural Route Number,
	he Hosp in 24 hou he Funei pietely fill	edical		ysician: To the best liner: On the basis of and manner st	of examina									
	To the To the Comp	Σ	29b. Signature and tiple of certifier	/ /	) ,	Ral	290	. License	number			29d. Da	ate signed (Mont	th, Day, Year)
•	(10)		30. Name and Indiress of person who of	completed cause of	death (Iten	n ZJa) (Type.	Print)	D313	319			Apr	ril 15,	2004
_	(20)		National Funera			ee Hwy		s Ch	urch	VA 2	22042			
3	St: Regist		31. Date filed (Month, Day, Year) APR 1 9 2004	2. Regist	rar's Signa		20		W11.					

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			For State Registrar	State of Mar	ryland /	Depa / Depa	artment of He tificate of D	ealth and Death	d Mental H	ygien Reg. N		. 14	556
	Discretel		1. Decedent's Name (First, Middle, Last,	)					2. Date of I Month		ay Year		e of Death
	Physicia /Medic		GERTRUDE				LAME	E	APRIL		3, 2004	7:	10A M
	Examin		4a. Facility Name (If not institution, give	·			4b. City, Town, or		ath	4	lc. County of De		
			HILLHAVEN NURSING  5. Social Security Number 6. Se		(In yrs. last	hinth do (1)	AL If Under 1 Year	ELPHI	Irs. 8. Date of I	Righ		OMERY	to or Foreign
	Funeral Director			M 2 TF	91	Yrs.	Months Days	Hours M	in. (Month.	Dav. Yea	1912 Ru	SSia	te or Foreign
	land ow		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Insid	e City Limits
	Mary I-f sh	to	Maryland Prince (	Georges	Adelp	ohi						1)(1)	∕es 2□No
	or 288	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What (	Country?	-
	23a c		3210 Powder Mill F	Road			20783				. S. A.		
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or Itams 23a or 28a-f show other than "naturel", or Itams 23a or 28a-f show event, the Medical Erarit were nast be notified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🎇 No		(Specify Yes or i erto Rican, etc.)	No-	14. Race - An Black, Wh Specify: Wh	nite, etc.	٦,
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	1	6a. Dece	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of v	working	16b.	Kind of Busines	s/Industry	
21	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+	)		00 NOT use retired) ssmaker		· ·		Garments	3	
	e filed within al Hygiene. I other than vent, the Ma		12 Years  17. Father's Name (First, Middle, Last)			DICE	Silicitor	18 Mother's N	Name (First, Midd				
Maryland	d be findal head of	Be c	Morris Amron						(Unknow		on Gamano,		
Z	should be tand Mental is marked o	유	19a. Informant's Name/Relationship (7)	vpe, Print)	1	19b. Mailir	ng Address (Street a				or Town, State	, Zip Code)	
	2 6 7 8		Martin Lampe - S				Van Burer						20782
ē,	permit. Pages 1 and Department of Health Importent: If item 21 any injury or other 1 once.		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of natory or other place	- <del> </del>	Date	20c.	Location - City of	or Town, State	9
Ë	Page mr: #		1 \Delta Burial 2 □ Cremation 3 □ F  1 4 □ Donation 5 □ Other (Specify)		1	-	ael Cemete		2/2004	Woo	odbridge	e, New	Jersey
Baltimore,	permit. Par Departmen Importent: any injury once.		21. Signature of Funeral Service Licens	600		20	Name and Address	of Eacility		ectio	on. Inc.		
<u> </u>	Depril Impo		Donald (.)	Stottlen	ryer	- 10	191 Rocky	ille Pi	ke, Rocl	cvil:	le, Mary	land	20852
ŀ			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused t ne cause on each line	death. [	Do not ent	er the mode of dying	, such as card	diac or respiratory	arrest,			mate Between and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Alzhe	imer'	s Di	sease					6 Yea	
	/Medical Examiner		resulting in doubly	Due to (or as a	consequen	ce of):							
		io io	Sequentially list conditions,	b. Due to (or as a	consequen	ce of):						-	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
Ć,	execting and and ial-trig	Exa	resulting in death) Last	Due to (or as a	consequen	ce of):							
68760,	rcate be executed physician and s the burial-transit	edicai	(	d									
			IF FEMALE:									1	
Вох	ath ce ttendi or use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1□Live birth 2	Fetal de	ath 3	Ectopic pregnancy				23d. Date of d Month	lelivery Day	Year
	the a	/sic	1 ☐ Yes 2X☐No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	ime of death	n 5L	Other (specify)			-		,	
P.0	that the de led by the a detached t	Ph	Part II. Other significant conditions co	ntributing to death but	not resultin	ng in the u	nderlying cause give	n in Part I.	23e. Di	d tobacco	o use contribute	to the cause	of death?
Records,	uires that signed b	d by		, and the second					1 (	Yes	2. No 3□	Probably 4	Unknown
Ö	w requir been si should	Completed							24a. W	as an	24b. Were	autopsy findu	nas available
Re	he lav e has	duc							– au	topsy rformed?	prior to	o completion	
Vital	ysician: The is certificate hi director, page	a)	25. Was case referred to medical					26. Place of [	1 ☐ Yes Death (Check oni		NO 1 1 1	es 2 No	
>	ysicia s cert direct	0 B	examiner?	Hospital: 1 ☐ Inpatien	t 2 ER	/Outpatier	nt 3 DOA Cthe		gHome 5□Re		6 ☐Other (Sp	pecify)	
J of	ding Phys h. After this funeral dii	T :u	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28	b. Time o	28c. Injury Work				jury occurred		
io	kttendin death. ctor: Aff y the fur	atio	2 Accident investigation			,,	M 1 🗆 Y	′es 2□No					
Division	or A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home (Specify)	a, farm, sti	eet, factory, office			(Street Fown, Sta	and Number or . ate)	Rural Route I	Vumber,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai		ysician: To the best of inar: On the basis of e and manner state	examination								se(s)
	To the To the comp	×	29b. Signature and title of certifier	18			29c. License				Date signed (Mo		ur)
	20		· wall	1 Bm	_		V3	1563		APR	IL 19,	2004	
			30. Name and address of person who o					0 7 7 7777	ם משחשים	74.4	DS/T AND	20001	
,			DR. CHARLES BENNER						x SPKING	, MA	KILAND	20901	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 2 200	32. Registrar	pushed	29	sparks	/					
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State of Maryland / Department of Health and Mental Hygiene 2 ()
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		•	1 - State Registrar	State of	Marylan		artment of <i>tificate of</i>		ınd Mer		iene2 () () ( <sub>4</sub>	14557
	Physicia /Medic		Decedent's Name (First, Middle, Last)		J. Lant	osh				Date of Deat Month pril 1	<sup>h</sup> 2004 Yeer	3. Time of Death 11:00A M
	Examin		4a. Facility Name (If not institution, give Friends Nursing I		nber)		4b. City, Town, Sandy S		f Death		4c. County of Deeth  Montgomer	·v
H	Funeral Director		192-03-2737	M 2 F	7. Age (In yrs. i 93	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. Ma	Date of Birth (Month, Day, ay 20,	Year) 9. Birthr Cour 1910 Czecl	olace (Stete or Foreign
	permit Fages I and 2 should be into whith 72 foots arise locatif with the maryana Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-1 show any injury or other traumatic event, the Medical Exandrac must be notified at once.	Funeral Director	Usuel Residence of Decedent  10a. State 10b. County  Maryland Montgome  10e. Street and Number  5513 Marlin Street		10c. City	y, Town or Lo	Rockvill 10f. Zip Code 2085				0g. Citizen of What Cour	
9500-	itural, or itame	ğ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  15. Decedent's Edu	Armed For 1 Tes If Yes, Give Year or Da	2 <b>∑</b> No e		Vas Decedent of f Yes, specify Cul	Specify:	, Puerto Rica	an, etc.)	14. Race - Americ Black, White, Specify: Whi	etc. Lte
01717	ygiene. her than "na it, ine Medic	Completed	(Specify only highest grad	College (1-	-4or 5+)	(Give life. l Welc	lent's Usual Occu kind of work done DO NOT use retire	əd) 			Steel Manuf	•
l ylaiid	d Mental H marked ott matic even	To Be	17. Father's Name (First, Middle, Last)  John Lantosh  19a. Informant's Name/Relationship (Ty	ne Print)		19h Mailir	n Address /Stree	Ma	ary D	etko	Maiden Sumame) , City or Town, State, Zip	(Code)
ב, <u>א</u>	Health an tem 2 s tem 27 is tem 27 is tother traus		Joanne Weil / Daug		20b. P	5513	Marlin S	treet,	Rock	ville,	Maryland 2	0853
	ourtment of portant: If i injury or injury or its		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		state	urrect	natory or other place. ion Cemet . Name and Addr	ery	pril 2 2004	F	Moon Townshi Pennsylvania Rockville, Ind	
	buy sicial be executed by section and buy sicial and buy sicial and the private transit the private state of the p	dicai Examiner	23a. Part1. Enter the disease, or complements of the complements of th	Due to (c	ach line.	n. Do not ent  L		ing, such as o		·	rille, Maryland	Approximate Interval Between Onset and Death
	ine law requires mai me deam cermicate date has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1□Live bi	come of pregna rth 2 ☐ Fetal ant at time of do wn	death 3	Ectopic pregnand Other (specify)	ey			23d. Date of delive Month	ery Day Year
ecords, P	equires man	by	Part II. Other significent conditions con	ntributing to de		ulting in the u	nderlying cause g	ven in Part I.			pacco use contribute to the	
al nec	cate has be	Completed							_	24a. Was ar autops perform 1 Yes 2	y prior to con ned? death?	psy findings available mpletion of cause of
VICA	certif	o Be	25. Was case referred to medical examiner?	lospital:				hom		heck only on		
	Attending rings r death. ector: After this by the funeral di	$\vdash$	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	_	npatient 2  If Injury h, Day Yeer)	28b. Time of Injury	28c. Inju	4 🔼 1901	28d.		once 6 Other (Specify ow injury occurred	0
DIVISION	to the tropical of Attending Friystcient. The law within 24 hours after death.  To the Funeral Directorakiter this certificate has sompletely filled in by the funeral director, page 2 to completely filled in by the funeral director, page 2 to the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place buildin	of Injury - At ho ng, etc. <i>(Specif</i> )	ome, farm, str	eet, factory, office		28f.	Location (St. City or Town	reet and Number or Rura , State)	l Route Number,
	ne nospii in 24 hour he Funeri oletely fille	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	sician: To the ner: On the ba and mann	sis of examinat	wiedge, death tion and/or inv	occurred at the trestigation, in my	ime, date and opinion, deat	d place, and h occurred a	due to the ca	ause(s) and manner as state and place, and due to	ated. the cause(s)
1	withii Comp	W	29b. Signature and title of certifier	sep re	les.		29c. Licen	re number			Pd. Date signed (Month,	
			30. Name and address of person who concerns to pher Mays, 31. Date filed (Month, Day, Year)	M.D.		rince		rive,	#328,	Olney	, Maryland	20832

Registrar

APR 2 3 2004 Kenne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 14558 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2004 April 6:40 A. George Edward Lichtblau /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Yrs. 84 March 6, 1920 Austria Director 061-14-5130 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State th and Mental Hygiena.
71s marked other than "natural", or Items 23s or 28s-1 show traumatic event, the Medical Evantral near that be notified at 1 Yes 2 □ No Maryland Montgomery Chevy Chase 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4515 Willard Avenue #910 South United States 20815 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II within 72 hours after 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Labor Attache Government 5+ 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Alice Fisher Ernst Lichtblau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If item 27 is cor other tra 4515 Willard Avenue #910 South, Chevy Chase, MD. 20815 Catherine Lichtblau/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) April 18, 20c. Location - City or Town, Stete 20a Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Montgomery permit. Page Department of Important: If eny injury or 2004 Bethesda, Maryland in in in ^ 4 □ Donation 5 □ Other (Specify) Crematorium, Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses Kut M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 3 Years disease or condition resulting in death) Ischemic Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ig physician and as the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 □ Yes 2 □ No jo 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hecords, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown End Stage Renal Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? page 1 Yes 2 🙀 No of @ o 6: ivision of Vital Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ₽ No 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 17, 2004 D37891

DHMH 17 Rev 1/2001

State Registrar

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Amit Rajvanshi M.D. 121 Congressional Lane #409, Rockville, Maryland 20852

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2004

			For State Registrar	Sta	ate of M	aryland	d / Depa <i>Cei</i>	artment of rtificate of	Health and Death	Mental Hy	/giene Reg. Na	200	4 145	59
2	Physici	an	1. Decedent's Name (First, Midd Hemelina	le, Last) Lin	ıde					2. Date of D	Da	ıy Yea		eath
	/Medic		4a. Facility Name (If not institution					4b. City. Town.	or Location of De	April		, 2004 County of De	0645	
	Examin	er	Shady Grove Adv					·	cville			Montg		
	Funeral		5. Social Security Number	6. Sex	7. Ag		ast birthday)	If Under 1 Yea Months Days	r If Under 24 H	rs. 8 Date of B	irth		irthplace (State or I Country)	Foreign
et,	Director		579-76-7037	1 M 2	M) -	93	Yrs.	Working Day.	TIOUTS IN	n. 8 Date of B (Month, D Oct. 2	8, 19	910	Cuba	
	and		Usual Residence of Decedent  10a. State 10b. County			10c. City	, Town or Lo	cation					10d. Inside City	Limits
	Many fied	ţō	Maryland Mon	ntgomer	. А	Ro	ockvil	le					1 ∑ Yes 2	! □ No
	h the	Director	10e. Street and Number					10f. Zip Code			10g. Ci	tizen of What	Country?	
	23a c		1235 Potomac	/alley	Road			20	0850		Uni	ted St	ates	
	ar dea	Funerai	11. Marital Status	An	as Decedent med Forces?			Was Decedent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or N erto Rican, etc.)			nerican Indian,	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	. tf \	Yes 2 7 Yes, Give ar or Dates:	No		1⊠ Yes 2□ No	Specify: (	Cuban		Specify: W	hite	
8	tied within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28e-f show ent, the Medical Examiner must be notified at	ted	15. Decede	nt's Education			16a. Deced	dent's Usual Occi	upation		16b. F	(ind of Busines	ss/industry	
215	thin 7. B. Bn "n	pie	(Specify only higher Elementary/Secondary (0-12)		oleted) Illege (1-4or:	5+)		kind of work don DO NOT use retir	e during most of w ed)	vorking				
7	ed wi	Completed	12					Homen				Own Ho	me	
Maryland 21215-0036	l be fit ad oth even	Be	17. Father's Name (First, Middle Isidro Do	<i>Last)</i> omenech					Juana	ame (First, Middle Perez	e, Maider	n Sumame)		
Ž	should be and Mental smarked o	ြ	19a. Informant's Name/Relation	shin /Tvna Pr	int)		19h Mailir	ng Address (Stree		Rural Route Numb	ner City	or Town State	Zin Code)	
	and 2 s ealth ar n 27 is			nde/Son						Washingt				
Je,	s 1 a of Hea item othe		20a. Method of Disposition	. 70		1 00	ace of Dispo	sition (Name of natory or other pl		il 24,	•	ocation - City		
Ē	Pages nent of heart of heart of heart. If its ury or of		1 ☐ Burial 2 反 Cremation 14 ☐ Donation 5 ☐ Other (3		al from State		Montg	oméry ium, Inc	20		Bet	hesda,	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other treumatic event, the Mudical Examiner is use the rutillise at once.		21. Signature of Funeral Service	Licensee	_	M0135	66 Be	Name and Add thesda-C thesda,	ess of Facility Reshevy Cha Maryland	obert A. Ise Inc. 20814-	Pum 755 3501	phrey F 7 Wisc	uneral Ho onsin Ave	ome/ nue,
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complication t only one cau	s that caused se on each li	d the death. ne.	. Do not ent	er the mode of dy	ing, such as cardi	ac or respiratory	arrest,		Approximate Interval Betwe	
	Physician		Immediate Cause (Finat disease or condition resulting in death)	a		Se	psis						Onset and De	alfi
L	/Medical Examiner		, octaining in country		Due to (or as			umonia						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. —	Due to (or as			diiioiita						
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	G	Adva	nced	Demen	tia						
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8760,	icate be executed physician and s the burial-transit	dicai		d	Atri	al Fi	brill.	ation_						
χ	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant		es, outcome							23d. Date of d	elivery	
.O. Box	at the death certifii I by the attending patached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	40	∃Live birth ∃Pregnant a ∃Unknown			Ectopic pregnant Other (specify)	су			Month	Day Yea	ar
<u>Р</u>	at the d by th etache	Phys	9 Unknown											
ords,	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant condit	ons contributi	ng to death b	out not resul	iting in the ur	nderlying cause g	iven in Part I.				to the cause of dea Probably 4 DUnk	
Division of Vital Records,	The law rate has be page 2 sh	Completed								24a. Was auto perf 1 ☐ Yes	psy ormed?	prior to death?	autopsy findings ava completion of causes 2 No	ariable se of
ta		Be C	25. Was case referred to medica examiner?	ıl L					26. Place of D	eath (Check only	2x No one)	1016	5 2 140	
<u>&gt;</u>	Physic this ceral dire	၉	1 ☐ Yes 2 🙀 No	Hospita	1 🔯 Inpatie		R/Outpatien	1 3 DOA 0	ther: 4 Nursing	Home 5 ☐ Res	idence	6 □Other (Sp	ecify)	
Z C	Attending Physician: It death. ector: After this certification in the funeral director.	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	ng	. Date of Inju (Month, Da	y Year)	28b. Time of Injury		ork?	28d. Describe	how inju	ry occurred		
Sic	l or Attend after death Director: .	ficat	3 ☐ Suicide 6 ☐ Could	not be 28e	. Place of Ini	urv - At hon	ne farm str	eet, factory, office	]Yes 2 □No	28f. Location	Street ar	nd Number or E	Rural Route Number	r
2	el or A s after al Direct	Certification:	4 ☐ Homicide determ	ninea	building, et	c. (Specify)		551, 145151y, 511160		City or To	wn, State	9)	Total Front Framos	
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	To the within 2 To the complet	Me	29b. Signature and title of certific	1	A			29c. Licer	se number		29d. Da	te signed (Mor	oth, Day, Year)	
	5		> XXLS	·24	AMIT	~(	ř	D-	59284		Apri	1 21, 2	2004	
_			30. Name and address of person Shahid Shamim,		1299	Lambe	rton I	Drive, S		ring, M	ary1	and 20	1902	
	Sta		31. Date filed (Month, Day, Year		32. Registr	ar's Signatu	ле Д	Spark	2					
	Registr	ar	APR 2	5 CUU4	1		/	- /						

State of Maryland / Department of Health and Mental Hygiene  $200\,\mathrm{L}$ 14560 For State Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Lillian LOCKE April 18, 2004 4:45 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Nursing & Rehab. Center Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 💢 F Director 014-22-1907 96 Aug. 10, 1907 Massachusetts Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State rai', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18531 Boysenberry Drive #290 20879 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: white þ 3 Widowed 4 □ Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DD NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygienn important: If item 27 is marked other thin eny injury or other traumatic avent, ITE 0006. 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Schenk Gustav Mahler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9323 Grazing Terrace, Gaithersburg, MD 20886 Barry Locke, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 04/21/04 4 

☐Donation 5 
☐Other (Specify) Pride of Jacob Cemetery West Roxbury, MA 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Fundral Service License 23a. Pert1. Ealer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Approximate Interval Bety Onset and Death tmmediate Cause (Final disease or condition resulting in death) Stroke Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, and leading to make a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4☐ Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Colon Cancer 1 Yes 2 No 3 Probably 4 XUnknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Breast Cancer 24a. Was an autopsy performed? certificate Hypertension 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No death, investigation 2 Accident within 24 hours after deati To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical one) and manner stated. ŧ, 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 28656 April 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D., 8609 - 2nd Ave., #404, Silver Spring, MD 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 20 2004 APR Registrar

State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** LOEVINGER Ruth April 18 2004 12:41 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F 227-30-7639 Director 29, 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Medic Examiner must be refilled an once. 1 XYes 2 No Gaithersburg Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20877 #408 419 Russell Avenue Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 217 No Yes, Give 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Public High Schools in Elementary/Secondary (0-12) College (1-4or 5+) Career Information CoordinatorMontgomery County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Libby Winick Joseph Schimmel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) One Salem St., #13B, Swampscott, MA Neal Loevinger, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 04/19/04 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Zhows /Medical resulting in death) Due to (or as a consequence of) **Examiner** Scheniz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2D No certificate 1 Yes 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartific April 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rochalle, MD 5had 5725 Kichad Weshstan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 0 2004 APR Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 14562 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer uff 0540 AM -rank 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) May 4, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 1**∑**M 2□F 507-09-0397 81 NE

> 10d. Inside City Limits 1 X Yes 2 □ No

10g. Citizen of What Country?

United States

14. Rece - American Indian,

Bfack, White, etc.

10c. City, Town or Location

12. Was Decedent Ever in U.S. Armed Forces?

Gaithersburg

10f. Zip Code

20877

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

**Funeral** Director Funeral Director

**Physician** 

/Medical

**Examiner** 

1 - For State Registrar

10a. State

MD

Usual Residence of Decedent

10e. Street and Number

11. Marital Status

10b. County

Montgomery

415 Russell Avenue, #713

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23s or 28e-f show any injury or other traumatic event, the Medical Exp. Items 2. and but rediffed at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

To the Hospital or Attending Physicien: The law requires that the death certificate be executed filled in by the funeral director, page 2 within 24 hours after death.

To the Funerel Director: A completely filled in by the fi

Division of Vital Records, P.O. Box 68760,

by Fu	3 ☐ Widowed 4 ☐ Divorced Ye	XYes 2 No Yes, Give 1940 par or Dates: 1045	-	1 ☐ Yes 2 🛣 No	Specify:	noun, old.,		White
Completed	15. Decedent's Education (Specify only highest grade com	pleted)	16a. Deci	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of w	orking	16b. Kind of Busi	iness/Industry
omo	Elementary/Secondary (0-12) Co	ffege (1-4or 5+) 5+		ectric Eng			Gover	nment
Be	17. Father's Name (First, Middle, Last)	_	.,			ame (First, Middle, M	·	)
10	Leslie Albert Luf	£			Althe	a Pearl Ba	aldwin	
4.	19a. Informant's Name/Relationship (Type, Pr	int)		_		Rural Route Number,	-	
	Mary Corrigan Luff/ W				venue,		hersbur	g, MD 20877
0	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Remov  4 □ Donation 5 □ Other (Specify)	al from State	metery, cre	position (Name of sematory or other place Heaven	Apr	11 20		ity or Town, State pring, MD
KITEG	21. Signature of Funeral Service Contract  CACIA TUW		2	22. Name and Addres	ss of Facility		eral Hom	e, 10 East 20877
	23a. Pert 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final	se on each line.		nter the mode of dyin	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	resulting in death)	Ove to (or as a conseque						1 YEAR
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Citecate of Irjury that initiated events resulting in death) Last	Due to (or as a conseque						
Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	res, outcome of pregnan ∃Live birth 2 □ Fetal o □Pregnant at time of dea □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	
		ng to death but not resul	ting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
ed b	PLEURIS EFFUSIVE	PERILIPESI	Y 5	FF Willes	CHE	1 □ Ye	s 210 3	☐ Probably 4 ☐ Unknown
Completed by						24a. Was ar autopsy perform	prio ned? dea	ore autopsy findings available or to completion of cause of ath?
Ö					26 Place of D	1 Yes 2	/	Yes 2 No NA
0	examiner?	il: 1 > patient 2 E	R/Outpatie	ent 3 DOA Othe		Home 5 Reside		(Specify)
ation: T	The second secon		28b. Time Injury	of 28c. Injury Work	at	28d. Describe ho		
Sertification:		Place of Injury - At hon building, etc. (Specify)	ne, farm, s	treet, factory, office	**Thosainte-de-	28f. Location (Str City or Town	eet and Number , State)	or Rural Route Number,
Medical C	29a. Certifier 1 Certifying Physicien (Check only 2 Medicel Exeminer: O							
×	250. digitatore and the or continor			29c. License	number	29	d. Date signed (	Month, Day, Year)
1	De Huse Henr-	-			58544	- P	PRIL 17	, 2004
	30. Name and address of person who complete				MUE # 5	15, WAGO	FUM, MI	p 2090E

State

Registrar

DR LIBUSE 31. Date filed (Month, Da

R 21

2004

32. Registrar's Signature

UNK 04-137		State of	rint in Black in Maryland / Den	artment of Health	sure All Copies and Mental Hyd	Are Legible.	8 & 10m on on
04-2706		For State Of Registrar	Ce	ertificate of Deat		10g. No.	14563
AKG	Jan	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death
Physic /Med		DORIS REBECCA			April	19, 2004	2:48 P M
Exam	ner	4a. Facility Name (If not institution, give street and nun	ber)	4b. City, Town, or Location	n of Death	4c. County of Death	
Funera			. Age (In yrs. last birthday		er 24 Hrs. 8. Date of Birth	Montgomery 9. Birthpla	ace (State or Foreign
Directo		213-24-7975 1□M 2ᡚF	75 Yrs.	Months Days Hours	er 24 Hrs. 8. Date of Birth Min. OCT 19	,1928 Mary	Mand
and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10	d. Inside City Limits
Mary 1-f she	ţō	Md Montgomery	Poole	sville			Yes 2□No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 te marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be natified at	Funeral Director	10e. Street and Number		10f. Zip Code 20837	1	Og. Citizen of What Country U.S.A.	ry?
eath weath w	erai	19411 Jerusalem Road			Origin? (Specify Ves or No.	14. Race - America	n Indian
of the red	Fun	Armed For 1 □ Never Married 2 □ Married 1 □ Yes	<b>≥CX</b> V0	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic		Black, White, et	tc.
OUIS a	d by	3 Vidowed 4 ☐ Divorced If Yes, Giv Year or Da	tes:	1 ☐ Yes XXNo Specia	fy:	Specify: Bla	ck
15-C	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupation e kind of work done during m DO NOT use retired)	ost of working	16b. Kind of Business/Indu	istry
12: I withii iene. I he M	ошо	Elementary/Secondary (0-12) College (1		mestic		Private Fa	mily
e filed al Hyg	BeC	17. Father's Name (First, Middle, Last)		18. Mot	ther's Name (First, Middle,		
Val buld b Ments	JO.	Fletcher Honemond				ayne	
Maryland 21215-0036 nd 2 should be filed within 72 hours aft th and Mental hygiene. 27 le marked other than "natural", or traumatic event, the Medical Exami		19a. Informant's Name/Relationship (Type, Print) Patrica Lee (Daught		ing Address (Street and Num 37 Suffolk	nber or Rural Route Number Terr, Gait	r, City or Town, State, Zip C .hersburg ,	Md 20878
re,   Fleating Theating		20a. Method of Disposition		osition (Name of ematory or other place)		20c. Location - City or Tow	
Page Int. If I		**XXBurial 2 □ Cremation 3 □ Removal from 5 ** 4 □ Donation 5 □ Other (Specify)	Ellijah	Cemetery	4/26/04 P	oolesville	, Md
Baltimore, permit. Pages 1 ar Department of Hea Important: If item? any injury or other	١,	21. Signature of Funeral Service Licensee	1 2	22. Name and Address of Fac Snowden Fur	neral Home	P.A. 20850	
W 605 60	1	23a. Part 1. Enter the disease, or complications that ca	len	246 N. Wash	nington St,	Rockville	Approximate
		shock, or heart failure. List only one cause on ea	ch line.	ner the mode of dying, such a	as cardiac or respiratory arr		Interval Between Onset and Death
≥ Physician ∠/Medica	_	disease or condition resulting in death)	r as a consequency (f):				
Examine		Sequentially list conditions. b.	0				
bed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Causes (Listate of injury that initiated events c.	r as a consequence of):				
760, le be execut ysician and e burial-tran	xan	that initiated events c. resulting in death) Last Due to (	r as a consequence of):				
760, te be executed ysician and	cai	d.					
Box 68 eath certificat attending phy for use as th	Physician/Medi	IF FEMALE:					
death co	ian/	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month D	y Day Year
P.O. nat the do do by the letached	hysid	1 Yes 2 No 9 Unknown					
ords, P.O. Box 687 requires that the death certificate seen signed by the attending physhould be detached for use as the	by P	Part II. Other significant conditions contributing to de	ath but not resulting in the t	underlying cause given in Par		bacco use contribute to the	
Or Or requ	sted				1 🗆 Ye		
Rec ne law nas b	Completed				24a. Was a autops	y prior to comp	sy findings available pletion of cause of
Vital Rec olcien: The lav certificate has		25. Was case referred to medical		26 Pla	ce of Death (Check only on		P□ No
f Vi	To Be	examiner? 1XXes 2 □ No Hospital: 1 □ Ir	patient 2 ER/Outpatie	ent 3 DOA Other: 4 1	Nursing Home 5 ☐ Reside		At scene
ing PI			Injury 28b. Time of Injury	28c. Injury at Work?		t drowned	-ef
isic trand death ctor:/	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e, Place	of Injury - At home, farm, st	M 1 ☐ Yes 2 (	28f. Location (St	reet and Number or Rural I	Route Number.
Div	Certification:	4 Homicide determined buildir	g, etc. (Specify)	en	White's	terry Poton.	CRIVER
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only  1 Certifying Physician: To the 2 Medical Examiner: On the ba	sis of examination and/or in	th occurred at the time, date	and place, and due to the ca	ause(s) and manner as stat ate and place, and due to t	ted. he cause(s)
thin 24 the Formplet	Medical	one) and mann 29b. Signature and title of certifier	er stated.	29c. License numbe		9d. Date signed (Month, Da	
<b>A E S E S</b>		Plat ()	- Polle	O.C.M.E	. A	pril 20, 200	)4
9		30 Name and address of person who completed cause	of death (Item 23a) (Type	, Print)			
N/A		31. Date filed (Month, Day, Year) 32. Rg	gistrar's Signature		reet, Baltimo	ore, Maryland	21201
Regis	tate trar		eper 6	sparks			

State of Maryland / Department of Health and Mental Hygiene? 14564 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death April **Physician** Thomas Edward Lamb, Sr. 18 2004 10:00P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Home Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 8, 9. Birthplace (State or Foreign Country) Virginia **Funeral** Months Days Hours Min. 217-32-7244 69 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits i Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f ahov other traumstic avant. I'm Medical Examinar must be notified at Frederick 1 Yes 2 No Maryland Director Libertytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12124 Main St. 21762 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "naturel", or Item Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1957-63 Year or Dates:957-63 1 ☐ Yes 2X No Specify: Specify.White 3 □ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mechanic/ part-owner auto service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Irving Lamb Sr. 2 Helen Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madge S. Lamb/ wife 12124 Main St. Libertytown, MD 21762 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 5 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. St. Peter's Cemetery 4/21/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Libertytown, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final disease or condition resulting in death) aur Priysician /Medical Due to (or as consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à cate has been sig, page 2 should b 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of D. ath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) E. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL ed cause of death (Item 23a) (Type, Print) Kaufmann Robert L. 300 W. 9th St. Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar 2004

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0

			1 - For State Registrar	State of Maryla	Cei	rtificate of	Death	A	eg. No.	11000
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Doris Stoll	League				2. Date of Dea Month April	Day Year	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Death	Aprii	12 2004 4c. County of Dea	2:50 P M
*	in the		2020 Kingshouse R				er Spring		Montgo	omery
* 12	Funeral Director		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	M 21XF 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day June 23		thplace (State or Foreign ountry) Shington, DC
	yland		10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	Director	Maryland Montgome	ry			er Spring			1 ☐ Yes 2 📉 No
	death with the Maryland ms 23a or 28a-f show rmust be notified at		10e. Street and Number	D 1		10f. Zip Code	2005	1	log. Citizen of What C	ountry?
	death	Funeral	2020 Kingshouse	2. Was Decedent Ever in Armed Forces?	U.S. 13.		20905 Hispanic Origin? (Spe pan, Mexican, Puerto	ecify Yes or No-	U.S.A. 14. Race - Am	
030	be filed within 72 hours after death with the Marylan tal Hygiene.  al Hygiene.  do ther than "natural" or Items 23a or 28a-1 show event, the Medical Examination must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	)	1 □ Yes 21√2 No		rican, etc.)	Black, Whi	White
212-0030	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occu kind of work done	during most of work	in <i>g</i>	16b. Kind of Business	/Industry
	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire Lypesette			Georgetown	n University
and	e fited v al Hygie I other t vant, in	Be C	17. Father's Name (First, Middle, Last)			J.1	18. Mother's Name		Maiden Sumame)	•
<u>yla</u>	ould b Menta	70	Charles Stoll					ude Stil		
Mary	es 1 and 2 should be fi of Health and Mental H if item 27 Is marked of ir other treumatic evan		19a. Informant's Name/Relationship (Ty) Richard L. Leagu						r, City or Town, State, nantown, MI	
Baitimore,	of Heroffitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b emoval from State	Place of Dispo cemetery, crei	sition (Name of matory or other pla			20c. Location - City or	Town, State
Ē	permit. Pages Department of Himportant: If ite eny injury or of pages.		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Euneral Service License	Ar		Nat'1 C	Citte		Arlington	
g	Depa Impo Impo eny i		Deollon	Duxos	. 11	800 New	Hampshire	Av., SI	lver Sprin	Home, Inc. ng, MD 20904
	<i>₩</i> .		23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the de e cause on each line.	ath. Do not ent	er the mode of dy	ing, such as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		g Cance	r				
	Examiner			Due to (or as a cons	equence or):					
H	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					347
	xecute and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
09/8q	ificate be executed g physician and as the burial-transit	edical								
Ξ.		/Med	IF FEMALE:	3c. If yes, outcome of preg	nancy				224 Date of de	li
O. Box	It the death certif by the attending tached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	;y		23d. Date of de Month	Day Year
۲.	uires that to signed by d be detact	y Ph	Part II. Other significant conditions con	tributing to death but not r	esutting in the u	nderlying cause gi	ven in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
ords	w require been sig should b		Diabetes				-	1 🗓 Y	es 2 No 3 P	robably 4 Unknown
Vital Records,	has has	Completed						24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of
VIta	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		0:	26. Place of Death	(Check only on	e)	
ō	Phys	To : T	1 ☐ Yes 2€ No  27. Manner of Death	28a. Date of Injury	28b. Time o	30 000			ence 6 Other (Special Company)	ocity)
ion	anding I ath. or: After	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ]Yes 2 □ No			
Division	al or Attending s after death. al Director: After ed in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (SI City or Town	reet and Number or R n. State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (		ician: To the best of my k ner: On the basis of exami and manner stated.						
	To th To th comp	Me	29b. Signature and title of certifier	8			se number		9d. Date signed (Mon.	
	(D		Ellen m	11001			0051015		pril 13, 2	004
	•		30. Name and address of person who co Ellen Pinholt, M				r Reed Arm	-		
	Sta Registr	- 71	31. Date filed (Month, Day, Year) APR 15 200	32 Begistrar's Sig		Spark				

		1	For State Registrar		State of	f Marylar		artment of F rtificate of			giene Reg. No		14300
			Decedent's Name	(First, Middle, La	ist)					2. Date of De		v Year	3. Time of Death
	Physicia		Mariori	o Loopor	•					April	Da 9.	2004	1:45 P M
	/Medic Examin	_	la. Facility Name (If I			mber)		4b. City, Town, o	r Location of Dea		-	. County of Deat	
	Examin	21	Shady Gr	_			1	Rockvil	1e		Mo	ntgomer	У
	Funeral		5. Social Security Nu			7. Age (In yrs		If Under 1 Year	If Under 24 Hrs		th Vear	9. Birti	nplace (State or Foreign untry)
1	Funeral Director		487-03-7	394	1□M 2XF	89	Yrs.	Months Days	Hours Min	July 2	4,19	14 Mis	souri
	TO.	3-0	Usual Residence of D	Decedent									10d. Inside City Limits
	ylan			10b. County			ity, Town or Lo						1X□Yes 2□No
	a-f-	cto	Maryland	Montgome	ery	Ch	evy Cha	ıse					
	th the	Director	10e. Street and Num	ber				10f. Zip Code				tizen of What Co	untry?
	th wi	al	2701 Wash	ington A				20815				J.S.A.	
	dea	Funeral	11. Marital Status		12. Was Dece Armed Fo	edent Ever in to proes?	J.S. 13.	Was Decedent of H	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	-	14. Race - Ame Black, White	
9	or It	F	1 Never Marrie		1 ∐ Yes If Yes, Gir	ve		1 ☐ Yes 2√√ No	Specify:		į	Specify:	•
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow the M. cical Examiner rived be notified at	Completed by	3€ Widowed 4		Year or D	ates:	100 0000	dent's Usual Occur	netion		16b k	Whi	
5	72 h	lete	(Specif	15. Decedent's E fy o <i>nly highest gi</i>	rade completed)		(Give	kind of work done  DO NOT use retire	during most of wi	orking	100.1	and or basinessa	
121	vithin ne. han	du.	Elementary/Secon	dary (0-12)	College (	1-4or 5+)			-/			Domesti	C
2	lled v lygie ther t	ပိ	17. Father's Name (F	First Middle Las	12		HOI	nemaker	18. Mother's Na	ame (First, Middle	, Maidei		
Maryland	ntal H	Be			7				Ester	Gershon			
Ž	hould d Me mark matic	٦ و	Benjamin  19a, Informant's Nar		(Type, Print)		19b. Maili	ng Address (Street				or Town, State, 2	Zip Code)
Ma	d 2 sl th an 7 Is r		Jerry Lee		(1)			Washingt					
Θ,	1 and Healt em 2 ther		20a. Method of Dispo			20b.	Place of Disp	osition (Name of		Date		ocation - City or	
٥	on it of		1 🖾 Burial 2 🖸	Cremation 3	Removal from			matory or other pla	1	. 11 200	7.	Des Med	mag Torre
Baltimore,	t. Partmer		*4 □Donation :			Je		Lendale C 2. Name and Addre		11, 200			nes, Iowa Home
Bal	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Microf Examiner must be notified at any injury or other treumatic event, the Microf Examiner must be notified at once.		Van	4. 1/k	be		11	1800 New	Hampshir	e Avenue	Si		ing,MD20904
*			23a. Part 1. Enter th shock, or hear	e disease, of colt tailure. List onl	mplications that of your one cause on o	caused the de each line.	ath. Do not en	ter the mode of dy	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
100	Physician		Immediate Cause (F	Final	Pne	uma	ma						UNKNOWL
-	/Medical		resulting in death)	-	_	(or as a conse							,
а	Examiner		Sequentially list con	nditions	b. Cer	ebroy	ascu	lar Ac	-Ciden	X			Unknown
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ó,	be executed ician and burial-transit	ũ	resulting in death) L	.231	Due	(or as a conse	equence on.						
8760,	cate be ex physician the buria	dical		•	d								
9	ing p	9	IF FEMALE:		00-16							and Date of de	
Вох	The law requires that the death certificate be executate has been signed by the attending physician and page 2 should be detached for use as the burial-trans	by Physiclan/M	23b. Was decedent in the past 12		1 Live	itcome of preg birth 2 □ Fe	tel death 3	Ectopic pregnand	су			23d. Date of de Month	Day Year
-	it the dea by the a tached for	sic	1 ☐ Yes 2 X		4∐Preg 9∐Unkr	nant at time of nown	ideath 5	Other (specify)					
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	res tha iigned I be det	by	Part II. Duler signin	Cant Conditions	contributing to t	Joan Dat Hot I	300 km /g m / m/0	on donying dadoo g		10	Yes :	2√2 No 3 □ P	robably 4 Dunknown
Vital Records,	w require been sig should b	Completed								- 1			tener findings available
ec	law nasb	nple								24a. Was		prior to death?	utopsy findings available completion of cause of
= H	The la	Con								1 ☐ Yes			2 □ No
/ita	ician: Th certificate rector, pag	Be	25. Was case referrence examiner?	red to medical	(In anital)					eath (Check onl	one		
2	Physic this c	2	1 ☐ Yes 2 🔀				☐ ER/Outpatie	ent 3 DOA		Home 5 Res			icify)
Division of	Attending Physician: r death. ector: After this certified by the funeral director. I	on:	27. Manner of Death 1√Natural	h 5 🗌 Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time Injury	We	ork?	28d. Describe	now in	dry occurred	
Sio	death. ctor: A y the fu	catl	2 Accident	investigat 6 ☐ Could not	bo				]Yes 2 □No	not Leastion	/Stroot	and Number or D	ural Route Number,
Ξ	I or Atten after deat Director:	Certification:	3 Suicide 4 Homicide	determine	200. Flau	e of Injury - At ding, etc. <i>(Spe</i>	t home, tarm, s icify)	treet, factory, office	9	City or To			urzi noute ivarnoer,
Ω	ital curs af			1								(a) and manner of	o stated
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	aminer: On the	ne best of my k basis of exami nner stated.	nowledge, dea ination and/or i	th occurred at the nvestigation, in my	opinion, death oc	corred at the time	, date a	nd place, and du	s stated. e to the cause(s)
	o the ithin, o the omple	Me	29b. Signature and	title of certifier	67			29c. Licer	nse number		29d. D	ate signed (Mon	th, Day, Year)
			1	4.7	hertton	Je Mo	)	00	105981	1	Ap	ril 9	2004
	3		30. Name and addr				tem 23a) (Tvo	Print)	-		-		5
	_		Cristin	Parke			990	Medica	(centisi	DAVE RE	OCE	Ille m	aruland
2	2	ate	31. Date filed (Mon	th, Day, Year)	32.	Registrar's Sig	gnature 🔏	1	1.1			1	2004
	Regis			PR 16 <sup>2</sup>	004	Jenera.	B	ppour	3.00				

DHMH 17 Rev 1/2001

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Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Registrar

DHMH 17 Rev 1/2001

State

Randolph Road, #103, Rockville, MD 20852

4761

32. Registrar's Signature

Yames F. McMurry M.D.

12

2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 00 1 14568 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 4:00 April 2004 Marco Anthony Leonardi, Jr. Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Holy Cross Hospital Montgomery Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Months 1⊠M 2□F 579-40-4365 Director 71 Oct. 31, 1932 Washington, DC Usuel Residence of Deceden death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mantal Hygiene. 1997 te marked other then "natural", or items 23e or 28a-1 ehow other traumatic event, the Mudical Exertilise market to ricitied. 1 ☐ Yes 2 TNo Directo Maryland | Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3014 Chapelview Drive 20705 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White ģ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Leonardi, Sr. Rosa Leonardi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
important: If item 27 is
any injury or other trau
once. Maureen Leonardi/ Wife 3014 Chapelview Drive, Beltsville, MD 20705 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition April 12, 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Silver Spring Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fa me Marier Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): **Examiner** Kyphoscoliotic Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Small Bowel Obstruction and Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of deeth 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1⊠ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 🔀 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of wilhin 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifie (Check only one) and manger stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D18813 April 8, 2004 30. Name and address of reson who completed cause or death (Ite ype, Print) ira Tauber M.D. 32. Registrar's Signature 1304, Silver Spring, VD 20902 31. Date filed (Month, Day, Year) State 2004 APR 13 sacks Registrar

		1		epartment of Health and N Certificate of Death	ental Hygier هور.ا	/	14569
	Physicia		Decedent's Name (First, Middle, Last)  Leonard B. Linco	1n	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April 10,	2004 4c. County <i>o</i> f Dea	7:45 P M
	Examin	er	12 Martins Lane	Rockville		Montgome	ry
	Funeral Director		5. Social Security Number 6. Sex 12⊠ M 2 ☐ F 76 Y	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes Oct. 17,	9. Bin Co L927 New	thplace (State or Foreign buntry) Jersey
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location			10d. Inside City Limits
	Mary!	to	Maryland Montgomery	lockville			1X Yes 2 □ No
	th the	Director	10e. Street and Number	10f. Zip Code		Citizen of What Co	
	s 23a	ral	12 Martins Lane 11 Marital Status 12. Was Decedent Ever in U.S.	20850  13. Was Decedent of Hispanic Origin? (Sp		ited Stat	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic avent, the Modical Executivative notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No  If Yes, Give Year or Dates: WW II	If Yes, specify Cuban, Mexican, Pueric 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, Whit	
Maryland 21215-0036	in 72 hou n "nature Vedical E	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)		. Kind of Business	Industry
212	ed with giene er the	Com	4 Inv	restigator		deral Gov	vernment
and	t be fill ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)  Leonard B. Lincoln	Anna Du	e (First, Middle, Maid 11es	den Sumame)	
ĬŽ	should nd Me mark matic	ို		Mailing Address (Street and Number or Ru		ty or Town, State,	Zip Code)
ĭ,	and 2:			Martins Lane, Rocky			
Baltimore,	Pages 1 and of He and of H		1 ▼ Burial 2 □ Cremation 3 □ Bernoval from State	Disposition (Name of crematory or other place)  Apri No Memorial Park  200	1 14,	. Location - City or ockville,	Town, State  Maryland
Balti	permit. I Departm Importer any injur	ı	21. Signature of Funeral Service Licensee  M00198	22. Name and Address of Facility Robert A. Pumphrey 300 West Montgomery A	Funeral Ho	ome/Rocky	7ille, Inc. 20850-2805
l,			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac		1110,10	Approximate Interval Between Onset and Death 12 years
	Pnysician / /Medical Examiner		disease or condition resulting in death)  a. Interstitial I Due to (or as a consequence or				12 years
	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	r):			
30,	cate be executed obysician and the burial-transit	il Examiner	Cause duse ase or litiguty that initiated events resulting in death) Last  Due to (or as a consequence or	·):			
38760,	icate b physic	dical	d.				
.O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
Δ.	es the	ρχ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	III.		o the cause of death? robably 4
Records,	he law e has b age 2 sl	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 🙀	prior to death?	utopsy findings available completion of cause of
Vital	Physicien: T this certificat ral director, p	Bec	25. Was case referred to medical examiner?  Hospital:	Other	th (Check only one)		J
of	Phys r this ral dii	on: To	27. Manner of Death 28a. Date of Injury 28b. T	me of 28c. Injury at work?	ome 5K Residence 28d. Describe how in		ecify)
Division	or Attenificer death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No m, street, factory, office	28f. Location (Stree City or Town, S.		ural Route Number,
_	Hospitel A hours of Funerel ely filled	edical Ce	29a. Certifier  (Check only one)  1☑ Certifying Physician: To the best of my knowledge, 2☐ Medical Examiner: on the basis of examination and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
<b>.</b>	To the Hos within 24 hv To the Fun completely	Me	29b. Signature and title-of certifier	29c. License number  DOSS 9		Date signed (Mon	th, Day, Year)
~	411		30. Name and address of person who completed cause of death (Item 23a) (Saba Medhane, M.D. 10810 Connection	Type, Print) Cut Avenue, Kensingt	con, Marvla	and 20895	5
	Sta Registi		31. Date filed (Month, Day, Year)  APR 1 4 2004  32. Registrar's Signature	g Sporker.			

6:10 A M

State of Maryland / Department of Health and Mental Hygiene,

2004

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month  $12^{Day}$ **Physician** April Alexander Linthicum /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 

1**X**M 2□F

Montgomery 9. Birthplace (State or Foreign Months

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | North Pebruary 17, 1940 | Mary Land

10d. Inside City Limits

1 Yes 2 □ No 10g. Citizen of What Country?

United States 14. Race - American Indian, Black, White, etc.

Specify: White 16b. Kind of Business/Industry

Defense Contractor

18. Mother's Name (First, Middle, Maiden Sumame)

Somervell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Wall Street, Rockville, Maryland 20850

20c. Location - City or Town, State

Bethesda, Maryland

Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805

Approximate Interval Between Onset and Death

23d. Date of delivery Month Day Year

April

13

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

20VC 1)53317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16220 Frederick Road, Suite 213, Gaithersburg, Maryland 20877 Joseph Ball, M.D.

31. Date filed (Month, Day, Year) 32. Régistrar's Signature sacks Ryera

within 24 hours a To the Funeral C

To the

Medical

State

Registrar

DHMH 17 Rev 1/2001

Registrar

APR 1 9-2004

			1 - For State Registrar	State of Mary	land / Depa	artment rtificate	of H	ealth a	and Mer	ntal Hy	giene Reg. No.	2001	+	457	12	
	Physici	an	1. Decedent's Name (First, Middle, Last)  Jack Ly	yon						Date of De Month	Day		ar	3. Time of De	M	
	/Medic Examin	al	4a. Facility Name (If not institution, give s							2004 1:20 A M 4c. County of Deeth						
		er	St. Mary's Nursin		Leonardtown					St. Mary's						
	Funeral Director		5. Social Security Number 6. Sex 217-36-7366 1√2	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, November 9					ay, Year)							
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injuy or other treumatic event, II a Modical Exemiter must be notified at once.		Usual Residence of Decedent  10a. State  10b. County	100	c. City, Town or Lo	cation							10d.	Inside City	Limits	
		tor	Maryland St. Mary's Mechanicsville									1 ☐ Yes 2	No No			
980		Funeral Director	10e. Street and Number 27043 Thompson Corner Road 10f. Zip Code USA 10g. Citizen of What C							t Country?	?					
		by Funer	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     □ Yes 2☑ No Specify:						o- 14. Race - American Indian, Black, White, etc. Specify: White					
5-0		eted	15. Decedent's Educ (Specify only highest grade	(Give	cedent's Usual Occupation ive kind of work done during most of working					16b. Kind of Business/Industry						
121		Completed by	Elementary/Secondary (0-12)		life. DO NOT use retired)  Farmer					Agriculture						
1d 2		Be Co	17. Father's Name (First, Middle, Last)	10	18. Mother's Name (First, N				irst, Middle							
ylar		To E	Alexander Marshall Lyon					Roberta Ch					ing			
Baltimore, Maryland 21215-0036			19a. Informant's Name/Relationship (Type Sally C. Thompson	n Niece	PO	вох е	553		Lata,	MD 2	0646					
			20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)		Ob. Place of Dispo cemetery, crea Christ Church	osition (Name matory or oth Episco Cemete	ner place pal	e)	Date			HAPTI			ınd	
Balt			21. Signature of Furreral Service Lios 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, I P.O. Box 270 Leonardtown, Maryland 20													
	To the Hospital or Atlanding Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and upposite to the Funeral Director; After this certificate has been signed by the attending physician and upposite completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition  Myocardial Infarction  Approximate Interval Between Onset and Death Immediate.								ath					
			resulting in death)	Due to (or as a consequence of):  Coronary Artery Disease years												
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):												
oʻ		Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	C. Atherosclerosis  Due to (or as a consequence of):										rears		
8760,		edical	d	i												
ds, P.O. Box 6		Physician/Me	250. Was decedent pregnant 1 live high 2 Festel death 3 Ectonic pregnancy							23d. Date o Month	f delivery Da	y Ye	ar			
		by	Pulmonary Failure (lung failure)													
Records,		Completed	Chronic Obstructive Pulmonary Dise				p				topsy prior to completion of cause of death?					
Vital		0	25. Was case referred to medical		1 ☐ Yes 22 26. Place of Death (Check only one)					INO TEL 185 ZEINO						
o		tion: To B	examiner?  1 Yes 2 No H  27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of 28c. Injury at Work?  Injury  M 1 Yes 2 No					280	g Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred						
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined						28f.	28f. Location (Street and Number or Rural Route Number City or Town, State)					∋ <i>r</i> ,	
		edical C														
		Me	29b. Signature and title of enther 29c. License number								29d. Date signed (Month, Day, Year)					
	2 0		Eugene Gua	D02159					April 29, 2004							
_	540		30. Name and address of person who co Eugene Guazzo, M.D	. MD Infir	mary	25343	HUR	RY RI	D CH	APTIC	O M	D 20	621			
1	Sta Regist		31. Date filed (Month, Dans)	32. Registrar's	Signature	Book	30									

State of Maryland / Department of Health and Mental Hygiene 200 L Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician Ethel Frances Lowe April 19 2004 5:14 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5148 Aireys Road Cambridge Dorchester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5, Social Security Number 7. Age (In yrs. last birthday) Birthpface (State or Foreign Country) **Funeral** Months Days 1 ☐ M 215 F 214-30-7872 97 Yrs. 1906 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Example; into the motified at 1 Yes 2 No Dorchester Cambridge Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5148 Aireys Road 21613 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer commercial laundry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be fi Herbert L. Harper Nellie Grace Christopher 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia M. Bowers 5148 Aireys Road, Cambridge, MD daughter 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Peg Department Important: b any injury o East New Market Cemetery 4/22/04 \*4 □Donation 5 □ Other (Specify) East New Market, MD Thomas Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD Duth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condition Physician resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and the dor use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 KNO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes No certificate 1 Tyes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending М 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur# and title of certifier mujene who completed cause of death (ftem 23a) (Type, Print) Bym St Cambridge MD 30. Name and address of person 32. Registrar's Signature State 1 2004

**ORIGINAL** 

Registrar

			riease	State of Marylar				-		1 2 year mag 4
			1 - For State Registrar	State of Marytar		rtificate of			2004	14574
	⊋.		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		Irene Frances La					April 14		1:55 p M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, c	or Location of Death	1	4c. County of Dee Prince (	_
	Funeral		Future Care Pinev 5. Social Security Number 6.5			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	1	thplace (State or Foreign
	Director		220-32-5746	□M 2 <b>X</b> F 86	Yrs.	Months Days	Hours Min.	September		Maryland
pue	\$ <u></u>		Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
Maryl	-f sho	tor	Maryland Prince	George's	Clintor	า				1 X Yes 2 □ No
h the	or 28a a notil	Funeral Director	10e. Street and Number		01111001	10f. Zip Code		10	g. Citizen of What Co	ountry?
ath wil	238 0	ralD	9106 Pineview L		,		735		U.S.A.	
er de	itema ner m	une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	J.S. 13.	Was Decedent of I II Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
G Z IZ I 3-UU30 filed within 72 hours after death with the Maryland	al', or	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify: W	nite
72 ho	natur disal l	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of wor d)	king 1	6b. Kind of Business	/Industry
within	then "	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT u</i> se retire Lerk	d)		hiversity	Of Maryland
M belif	Hygie other	a)	17. Father's Name (First, Middle, Last	)	1 01		18. Mother's Nan	ne (First, Middle, M	aiden Sumame)	
yland buld be file	Aental rked o	To B	Benard Bur	ch			Mary	Dye	r	
Mary d 2 sho	and le ma	ľ	19a. Informant's Name/Relationship Tracy A. Preston			•			City or Town, State,	
1 and	lealth om 27 thar to		20a. Method of Disposition			osition (Name of	Street, v	Jarrenton,	Va 2018	
ages	Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or itema 23a or 28a-f show important: if item 27 is marked other then. In Medical Examinat must be notified at angle.		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, cre	matory or other pla 11 Cemete			Suitland,	
Saltimor sermit. Pages	oortan injur		21. Signature of Funeral Service Lice	1					eral Home,	
n a	Depar fmpo eny ir		H Const	ance Bas	ch 4	739 Balti	more Ave	., Hyatts	ville, MD	
			23a. Part1. Enter the disease, or con- shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not en	ter the mode of dyi	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Fatal Card		rhythmia				
	aminer			Hypertensi						
70	<u> </u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse					,	
ou, be executed	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of):					
	sician and e burial-transit	0		2	4-000					
Geath certificate	signed by the attending phys d be detached for use as the	Physiclan/Medic		0.						
BOX	tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Fet		⊒Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
	the at thed fo	ysicl	1 Yes 2 No	4☐Pregnant at time of 9☐ Unknown	death 5[	Other (specify)				22,
7 1	detac		Part II. Other significant conditions	contributing to death but not re	sulting in the u	ınderlying cause gı	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
COLOS, w requires t	been sign should be	ed by	Diabetes Mellitu	ıs				1 ☐ Yes	s 2 □ No 3 □ P	robably 4 🕅 Unknown
a co	as bee 2 sho	Completed	Renal Failure					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
T e	cate has	Con	Urosepsis					perform 1 Yes 2		2 □ No
Of VITAL	iis certificate director, pag	Be	25. Was case relerred to medical examiner?  1 Yes 2 No	Hospital:	3500	Ott		ath (Check only one	nce 6 Other (Spe	
P Phy	= =	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how		iciny)
DIVISION  I or Attending	rath. or: Aftu ne fun	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	on	Injury		Yes 2 No			
or Atte	after death. I Diractor: After d in by the funera	Certification:	3 Suicide 6 Could not determined		nome, larm, st ify)	reet, factory, office		28l. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
pital	within 24 hours aff To the Funeral Di completely filled in		29a, Certifier 1 X Certifying P	hysician: To the best of my kn	owledge, dea	th occurred at the ti	me, date and place	and due to the car	use(s) and manner a	s stated.
e Hos	e Fun	Medical		miner: On the basis of examin and manner stated.						
To th	withir To th comp	×	29b. Signature and title ol certifier				se number		d. Date signed (Mon	
/			1000000	<u>.</u>			51520		4-15-0	4
- (	2)		30. Name and address of person who Bahram Pishdad, N				E, Washir	gton, DC	20032	
	Sta	ate	31. Date filed (Month, Day, Year)	B2. Registrar's Sign						

State of Maryland / Department of Health and Mental Hygiene 001 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 15 12:18PM APRIL 2004 YVONNE D. MAXWELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT 802 S. MORRIS ST. OXFORD If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country)
 NEW JERSEY 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 ☐ F 77 Yrs. APR 23, 194-20-9223 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be nutified at XXYes 2 ☐ No OXFORD Director TALBOT the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ Items 23a USA 802 S. MORRIS ST 21654 Completed by Funeral filed within 72 hours after death 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3X Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LICENSED PRACTICAL NURSE HOSPITAL 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic ever 9 ages 1 and 2 should be nt of Health and Menta t: If item 27 is marked y or other traumatic e MARIE GENTA F. MACHOLD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEITH M. PFEIFER/SON 48 RIVERS EDGE RD., ANDOVER NH 03216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. CHESAPEAKE CREMATION CTR 4-21-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 JOHN MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☒ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: After 1. Natural 5 Pending after death. 2 🗌 No 1 Tyes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52251 Mallher Fisher 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Mortin Court Suite 1 Easts n Manyful MATTHEW FISCHER MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	laryland / Do	epartn Certific	ent of H ate of L	lealth a Death	ind M		iene ()	04	14576
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Theresa		I	McClu	skey			2. Date of Deat Month April	h Day 20. 20	Year	3. Time of Death 7:15 AM
	Examir		4a. Facility Name (If not institution, give s 3111 Trinity Driv		7)	4b.	City, Town, or Bowie	Location o	f Death		4c. Count	y of Death ce Ge	
	Funeral Director		130 20 07 10	M 27 F	ige (In yrs. last birth 76 Yr	Mo	nder 1 Year ths Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, June 29	, 1927	9. Birth Cou New	place (State or Foreign ntry) Jersey
	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at ance.	ral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince Ge  10e. Street and Number  3111 Trinity Drive	<b>a</b>	10c. City, Town	e 10	f. Zip Code 20	715			0g. Citizen of	What Cou	
9800	ours after dea iral', or Items	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	5? TNo X	If Yes	specify Cuba	Specify:	gin? (Sp , Puerto		Specii	ick, White, fy: Wh	ite
121215-(	led within 72 h lygiene. her than "natu nt, the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		r 5+)	Decedent's Give kind ife. DO N Secre	Usual Occupation of work done of the control of the	during most ()		ing	Pe	al Go entag	vernment
Maryland 21215-0036	2 should be finand Mental File marked ott	To Be	17. Father's Name (First, Middle, Last)  Conrad Henry  19a. Informant's Name/Relationship (Type)		19b. N			Reb and Numbe	a or or Rura	al Route Number	. City or Town		o Code)
altimore, N	Pages 1 and nent of Health int: If item 27 iry or other to		Mary Jones/ Daught  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of D	Disposition cremator erans	(Name of or other plac Cemet	ery	4/26	/2004	20c. Location Che1te	nham	, Maryland
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service License	90						bert E. ad, Bow			ral Home d 20715
2	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each	line.	4/01	mode of dyin		,		est,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Sue to (or s	is a consequence of								
P.O. Box 6	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death		pic pregnancy or (specify)					ate of deliv	ery Day Year
	quires that in signed by uld be deta	ed by Pr	Part II. Other significant conditions con	itributing to death	but not resulting in t	he underly	ing cause give	en in Part I.		23e. Did tob	1		he cause of death?
Division of Vital Records,		Completed								24a. Was a autops perform 1  Yes 2	y	Were auto prior to co death? 1 \( \text{Yes} \)	opsy findings available impletion of cause of 2/2/No
ξ	ysicien: Th is certificate director, pag	Be c	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	tient 2 ER/Outp	ationt of	DOA Othe	or:		me 5 X eside		(0	£.,
ion of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific: completely filled in by the funeral director.	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ijury 28b. Tir		28c. Injun Worl	/ at		28d. Describe ho			у)
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined		njury - At home, farn etc. <i>(Specify)</i>	n, street, f	ctory, office			28f. Location (St. City or Town		ber or Run	al Route Number,
	the Hosp in 24 hou the Funer npletely file	Medical	29a. Certifier Check only one)  29a. Certifying Physical Examination (Check only one)	sician: To the best ner: On the basis and manner:	of examination and/	death occi or investig	ation, in my op	pinion, deat	d place, th occurr	ed at the time, da	ate and place,	and due t	o the cause(s)
	To with	-	29b. Signature and title of certifier	2			D3		3	2	9d. Date signe	la y	vey, rear)
	Sta	ate ·	30. Name and address of person who co	mpleted cause of	f death (Item 23a) (T	ype, Print)	N.	1-190	500	c T	Bon	15,1	207/6

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 = For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 16, a M Apr. 2004 5:15 Rose Winafred McGonigle /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 705 Capri Estates Court Anne Arundel Arnold Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F Ireland 83 Yrs. Jan. 10,1921 110-38-3217 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28e-f show Examiner must be nutitied at Arnold 1 ☐ Yes 2 No MD Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 705 Capri Estates Court 21012 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter may rightly or other traumatic event, the Medical Examina ☐ Yes 2 1 No f Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify. Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Patrick McDonnell Mary Kearney P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7613 Eaglet Court, Fort Myers, FL 33912 Laim McGonigle/Son Apr. 24 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Rochester, NY Holy Sepulchre Cem. 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Foperal Service Licensee 16mman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrougsculie Accident **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year for in the past 12 months? 5 Other (specify) I ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 12 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 1 ☐ Yes 212 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \to \) Nursing Home 5 \( \text{Thesidence} \) 6 \( \text{Other} \) (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 🗌 Yes 2 TIN this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending investigation 1 Tyes 2 No M death. 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Daje signed (Month, Day, Year 29b. Signature and title of certifier 29c. License number 2 K MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RK STEPHEN R040 103 MSON KATZ, 31. Date filed (Month, Day, Year) strar's Signature State APR 22

DHMH 17 Rev 1/2001

Registrar

2004

		-	For State Registrar		State	of Maryla	and / Dep <i>Ce</i>	artment <i>rtificate</i>	of H	ealth a Death	and M	ental Hy	giene Reg. No.		04	14578
		_	1. Decedent's Name	e (First, Middle	a, Last)			-				2. Date of De	ath Day	,	Year	3. Time of Death
	Physicia /Medica	al			laloney							April 1	19, 2	2004		9:33 a <sup>M</sup>
	Examine	er	4a. Facility Name (I	an Hos		number)		4b. City, To			of Death		4c.		of Death	
			5. Social Security N		6. Sex	7 Age (In v	rs. last birthday		the		24 Hrs.	8. Date of Bir	th .	Mc	ntgor 9. Birthn	nery lace (State or Foreign
	uneral		577.24.1		1 <b>∑</b> M 2□F		81 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 1ay 13	y, Year) 192	22	Coun	ngton DC
			Usual Residence of													
arylar	show	_	10a. State	10b. County		100.	City, Town or L									0d. Inside City Limits 1 ☐ Yes 2\dag{X}No
be M	28a-f	Director	10e. Street and Nu		gomery		Beth	esaa 10f. Zip C	Code				10g Cit	izen of l	What Coun	
with	De Or	흐	9707 Old		etown Roa	ıd			2081	L4				J.S.		, .
death	ms 23	Funeral	11. Marital Status		12. Was De	ecedent Ever in	n U.S. 13.	Was Decede	ent of His	spanic Or	igin? (Spe	cify Yes or No Rican, etc.)	<b>)</b> -		e - Americ	
after a	or Its		1 Never Marr		ied 1X Ye	s 2⊡NoW∏ Give	IIW	1 ☐ Yes 2		Specify:		nican, etc.)		Specif		
<b>5-0036</b> 72 hours aft	ural,	d by	3 Widowed	4 Divorced	Year or	r Dates:		edent's Usual		tion			16h Ki	ind of B	usiness/Inc	ite
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	ita ryylene. id othar than "natural", or Items 23a or 28a-f show evant, Ite Modical Examiner must be notified at	Be	17. Father's Name									(First, Middle		Suman	ne)	
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Mar d 2 sh	7 is n	- 1	19a. Informant's N		aline/ Da	unch+or	31					Route Numb	174			Code)
.1 an	tam 2 other		20a. Method of Dis		TIME/ Da		b. Place of Disp cemetery, cre	Alabama		ad		n, Mar			City or To	wn, State
mol	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =		1 🗆 Burial 2.		3 □Removal fro pecify)		It. Com				4-2	2-04	Alex	and	ria.	Virginia
Baltimore, Maryland	Department of Heatin and Menta Important: If itam 27 is marked any injury or other traumatic events.		21. Signature of Fu				2	2. Name and	Addres	s of Facili	ity Jos	eph Ga	wler	's :	Sons,	Inc.
<b>m</b> & 8	8 5 8		10	XC111.7	5000							e NW W		ngt	on DC	
				art failure. List	complications that only one cause of	at caused the d n each line.			,			_				Approximate Interval Between Onset and Death
	ysician Jedical		Immediate Cause disease or condition resulting in death)	on	_ a	astric		er o	45	ease	2 4	sty r	en	or	Lage	
	aminer		,		Dde	to (or as a cons	sequence of):									V
		ē	Sequentially list co It any, leading to in cause. Enter Undo Cause (Disease or	onditions,	b	to (or as a gone	sequence of):									
AM o,	ohysician and the burial-transit	Examiner	that initiated event	5	c											
7, 200 33 A 8760, ate be execut			resulting in death)	Last	Due	to (or as a cons	sequence of):									
978 876 cate b	physic the b	Physician/Medical			d											
Box 68	attending ph	/Me	IF FEMALE:		23c. If yes,	outcome of pre	gnancy							23d. Da	te of delive	irv
	atten for u	cian	23b. Was deceder in the past 12 1 Tes 2	2 months?	1□Liv 4□Pre	e birth 2 □ F egnant at time o	etel death 3	□Ectopic pre □ Other (spe							onth	Day Year
O. o.	by the	hysi	9 Unknow		9□Un	known						_				
deef Apr ecords, P.O. Bot law requires that the death	as been signed by the a	by P	Part II. Other signi	ificant conditi	ons contributing to	death but not	resulting in the	underlying ca	use give	n in Part	l,					ne cause of death?
of Vital Records,	een si tould l		are	ma.		N 0						ļ	Yes 2		3 🔲 Prob	
Oneth Record	has b	Completed	150	rem.	c care	210m	yopa	my				24a. Was		24b.	Were auto prior to cor death?	psy findings available inpletion of cause of
A Hair	certificate has rector, page 2		ene	98/03	e rena	1 duse	ase					1 ☐ Yes	2 <b>1</b> No	1	1 🗌 Yes	2□ No
of Vita	recto	o Be	25. Was case refe examiner? 1 Tes 2		Hospital:	Inpatient 2	2 ☐ ER/Outpatie	ent 3 DOA	Cthe			(Check only ne 5 ☐ Res		e □Orb	er (Specifi	()
of of	After this funeral di	$\vdash$	27. Manner of Dea	ıth	28a. Da	ite of Injury fonth, Day Year			c. Injury Work	at	-	28d. Describe				,
Vision Attanding	death. ctor: Afte y the fun	atio	1 ☑Natural 2 ☐ Accident		gation	ionin, Day 1 ea	injury	М		Yes 2 🗆	] No					
Division	iracto iracto iracto	Certification;	3 🗌 Suicide 4 🔲 Homicide	6 🗌 Could determ	inad   289. Pl	ace of Injury - A ilding, etc. (Sp	At home, farm, s ecify)	treet, factory,	office		2	28f. Location ( City or To	Street an wn, State	nd Numb n)	oer or Rura	l Route Number,
Spital o	within 24 hours after death.  To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page		20. 0. 48.	No francisco	an Dhuaisiana Ta	the best of our	kanuladaa daa	th converse do		- data a	ad place a	and due to the	201100(0)			entod
, h	24 ho	edical	29a. Certifier (Check only one)		ng Physician: To Examiner: On the and m											
o tha	vithin Fo the	Me	29b. Signature and	d title of certifie				29c.	License	number			29d. Da	te signe	d (Month,	Day, Year)
			•	12	n				57	7675			4/	19	104	f
_	12		30. Name and add	lress of person	who completed c	ause of death (					11 -	000 -			1	00011
00-			(	307L	L. 80	- Reciety of		5 Aubu	rn A	Avenu	1e, #2	202 Be	eyhes	sda,	м.Ф.	20814
0/-	Sta Registr		31. Date filed (Mo.	NPR 2.2	0001	2. Registrar's Si	e La La	200	reks	/						

		-	For State Registrar	State of Maryland		artment of Hertificate of D			giene,. Reg. No.		14579
			1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Helen M	Cloud				Apr	17	2001	0023 AM
	Examin		4a. Facility Name (If not institution, give		0	4b. City, Town, or	Location of D	Death		County of Death	
		3.	1100	reneval Hospita		If Under 1 Year	If Under 24	Hrs   9 Date of Birth		loward a Bitho	fece (State or Foreign
	Funeral		5. Social Security Number 6. Security Number 220-40-6372	7. Age (In yrs. In 60	ast σιπησαγ) Yrs.	Months Days		Min. 8. Date of Birth (Month, Day 2	G eer)	943 Coun	laryland
	Director		Usual Residence of Decedent								.2
	yland now		10a. State 10b. County		, Town or Lo					1	Od. Inside City Limits
	a-1-e	ctor	MD Howa	ra		Columb	ola 				Maryes 2 No
	or 28	Director	10e. Street and Number	7.1		10f. Zip Code	07045		10g. Citiz	en of What Cour	
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23s or 28s-f show the Medicial Examiner must be notilised at	rai	5433 Luckpe			M - B 4-1 - 400	21045		1.	U.S.A.	
	er de Item	Funeral	<ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes Ž∑ No	5. 13.	If Yes, specify Cubar	n, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		Black, White,	
36	rs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		5	Specify: B	Lack
5-003	2 hou	ted	15. Decedent's Ec		16a. Dece	dent's Usual Occupa	ation	of working	16b. Kin	d of Business/Inc	dustry
215	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	) -	Working	Re:	auty Sa	alon
N	fited with Hygiene. other ther	Completed	llth			Hair Sty		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
nd	tal Hy d oth	Be	17. Father's Name (First, Middle, Last)  Edward Beck				18. Mother's	s Name <i>(First, Middl</i> e, Margaret			
<u> </u>	should be and Mental I marked o	c			10b Maili	on Address (Street a	and Number	or Rural Route Numbe			Codel
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show may njury or other traumatic event, the Medical Examinating the notified at once.		19a. Informant's Name/Relationship (19a Richard McClo					Pl., Col			
	is 1 and 2 of Health a item 27 le other trau		20a. Method of Disposition	20b. P	lace of Dispe	osition (Name of	1	Date		ation - City or To	
Baltimore,	Pages nent of I ant: If it		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific	Removal from State	_ * *	matory or other place d Mem. P		4/21/04	Co	lumbia	, MD
ij	ortar	139	21. Signature of Funeral Service Licen	1 -1/		2. Name and Addres					HOME, P.A
Ä	permit. Departr Imports any inj		I does	Shouse	VIA			St., Rock		le, MD	20850
U	4		28a. Part1. Enter the disease, or com shock, or heart failure. List only	offications that caused the death one cause on each line.	n. Øo not en	ter the mode of dying	g, such as ca	ardiac or respiratory ar	rest,	.4	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. hypoxic							
	Examiner			Due to (or s a conseq	uence or):	ind in making	no the				
3.	, É 10	ē	Sequentially list conditions,	b. Due to (or as a consequence	uence of):	v coo vogo	projec	7			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G							
o,	an an an an irial-tr		resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	certificate be executed dring physician and use as the burial-transit	licai		d							
9	ertifica ling ph e as t	Physician/Med	IF FEMALE:	22a If you guiteeme of proges	1001	_				ad Data of data	
Box	death certific e attending p ed for use as f	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	☐Ectopic pregnancy ☐ Other (specify)			2	3d. Date of defive Month	Day Year
0	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	eath 5	Other (specify)					
٥.	law requires that the de as been signed by the a 2 should be detached b		Part II. Other significant conditions	ontributing to death but not res	ulting in the	underlying cause give	en in Part I.	23e. Did to	obacco us	se contribute to t	he cause of death?
Records,	uires n sign	d by						1`	Yes 2 □	No 3□Prot	pably 4 Unknown
00	w requir s been si should	ompleted						24a. Was		24b. Were auto	psy findings available mpletion of cause of
	lhe te h age	m o							rmed? 2 <b>5</b> No	death?	·
Vital		C	25. Was case referred to medical				26. Place o	of Death (Check only of			
<u> </u>	S S	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient	ER/Outpatie	ent 3 DOA Othe	er: 4 🗆 Nurs	sing Home 5 🗆 Resid	dence 6	☐Other (Special	(y)
n of			27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time fnjury	Worl	k?	28d. Describe I	how injury	cocurred	
sio	Attending r death. actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No		Ctrant and	Alumbar or Pum	J. Douto Number
Division	or Attend after death Diractor:	Certification:	4 Homicide determined		ome, farm, s	treet, factory, office		City or To			al Route Number,
	Hospital 14 hours a Funeral [ 16] filled		29a. Certifier 1 Certifying Pl	nysician: To the best of my kno	wledge, dea	th occurred at the tin	ne, date and	place, and due to the	cause(s)	and manner as s	tated.
	24 hc 24 hc etely	edical	(Check only 2 Medicel Examone)	niner: On the basis of examina and manner stated.	ition and/or i	nvestigation, in my o	pinion, death	occurred at the time,	date and	place, and due t	o the cause(s)
	To the Hospital or within 24 hours after To the Funeral Diraccompletely filled in the completely	Me	29b. Signature and title of certifier	* n		29c. License		4	29d. Date	signed (Month,	Day, Year)
	¥		> GATule	Lus		2000	0571	++	AF	ir 17	2004
			30. Name and address of person who		n 23a) (Type	. Print)		7 - 7 - 1. • -	345	21045	
			Evan Engl			cedar La	ine, (	Columbia,	MD	21045	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	L	1					

		•	For State	State of Maryland	d / Depa	artment of H	ealth and N Death	ental Hygi	iene 2004	14580
			Registrar  1. Decedent's Name (First, Middle, L.	ast)				2. Date of Death		3. Time of Death
	Physicia	an						Month April 1	7, 2004	2:40 PM
	/Medic Examin	- 4	Grace Louise  4a. Facility Name (If not institution, gi	McKenna ive street and number)		4b. City, Town, or	Location of Death	White I	4c. County of Deat	
	EXAMINI	GI.	Holy Cross Hosp	ital		Silver	Spring		Montgom	erv
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign
e.	Director		102-24-2893	1□ M 2対F 74	Yrs.	Months Days	Hours Will.	Aug. 9		y York
1000	5		Usual Residence of Decedent  10a. State 10b. County	10a Cibr	, Town or Lo	antina				10d. Inside City Limits
	arylar show	_	10a. State 10b. County	Toc. City,	, TOWIT OF EO	cation				1 ☐ Yes 2 ☑ No
	8a-f	Director	Maryland Montgo	mery E1	licott				Og. Citizen of What Co	
	vith tr	E	10e. Street and Number			10f. Zip Code			by. Citizen of what Co	unity :
	s 23	Funeral	4929 Brampton 1	Parkway 12. Was Decedent Ever in U.S	\$ 13.1	21043 Was Decedent of Hi	enanic Origin? (Sr	ecifu Yes or No-	USA 14. Race - Ame	rican Indian
	er de Item	Ë	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?	J. 13. 1	f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
36	Irs af	by	3 ☐ Widowed 4 🖺 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: Whi	.te
ğ	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or tems 23a or 28a-f show ent, tre Medical Exacts at must be rediffed at		15. Decedent's I	Education	16a. Deced	ient's Usual Occupa	ation		16b. Kind of Business/	Industry
212	nin 7.	ple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done a DO NOT use retired,	) )		Montgomory	Country
21	d with	Completed		2	Caf	eteria Ma			Montgomery Public	Schools
g	al Hy loth	Be (	17. Father's Name (First, Middle, Las	st)			18. Mother's Nam	e (First, Middle, M	Maiden Surname)	
<u>a</u>	Ments Ments arked	10	John Louis	McCoskery			Anna Ba	rbara Gr	een	
a	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show is marked other than "natural", or items 23s or 28s-f show aumatic event, it is Modicia. Exertified in	5	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rui	al Route Number,	City or Town, State, 2	Zip Code)
2	1 and 2 Health Iom 27		John J. McKen						MD 21769	Taura Ciata
ore	of H If Ite		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3	Pomoval from State	emetery, <u>c</u> rer	sition (Name of natory or other place		1 23,	20c. Location - City or	Town, State
Ē	Ment in Page		`4 □Donation 5 □ Other (Spec	ony)	Ceme				Silver Spr	ing, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Lice	ensee	F 22	name and Addres: nancis J.	collins Collins	Funeral	Home Inc.	
	00 F 4 0		(inchew)	-coce	5	00 Univer	sity Blv	d. W., S:	ilver Spri	MD 20901 Approximate
(KV3)			23a. Part1. Enter the disease, or co- shock, or heart failure. List on	mplications that caused the death. ly one cause on each line.	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Interval Between Onset and Death
Œ	Physician	0.1	Immediate Cause (Final disease or condition	<sub>a.</sub> High Grade	Left ?	remporal [	Glioma			
	/Medical Examiner		resulting in death)	Due to (or as a consequ						The Service of
	LXGIIIII CI	<u></u>	Sequentially list conditions,	b. Acute Cereb		cular Acc	ident			
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Klebsiella						
	and and al-trar	xan	that initiated events resulting in death) Last	C. Due to (or as a consequ		JIILLIS				
8760,	cate be executed obysician and the burial-transit			d. <u>Clostridium</u>	Diff.	icile Col	itis			
687	The law requires that the death certificate be executed to has been signed by the attending physician and ate 2 should be detached for use as the burial-transit	Physician/Medical		d. Olosellatan		TOTIC OUT	<u> </u>			
Box (	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Date of del	ivery
ĕ	death atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fetal 4□Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
0	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown						
ري ح	es that igned be be det	by P	Part II. Other significant conditions	contributing to death but not resu	ılting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rg.	quire on sig uld b	pa						1 🗌 Ye	s 2. Pro 3 □ Pr	obably 4 Unknown
00	as been si 2 should	Completed						24a. Was a		itopsy findings available
Re	The lay te has age 2	E						autops perform	ned? death?	completion of cause of
ta	i <b>cia</b> n: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	th (Check only on		
<u> </u>	Physician: r this certificanal director, I	0.0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 - E	ER/Outpatier	nt 3 DOA Othe	er: 4 🗌 Nursing H	ome 5 Reside	nce 6 Other (Spe	cify)
0	ding Phys h. After this funeral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				w injury occurred	
<u>io</u>	Attending or death. ector: After by the fune	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	ion			Yes 2 □ No			
Division of Vital Records,	I or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		me, farm, str	reet, factory, office		28f. Location (St. City or Town	reet and Number or Ri , State)	ural Route Number,
	ital or irs afte ral Dir led in								····	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examinat						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	25	9d. Date signed (Mont	h. Dav. Year)
1	Son Jaint		September 2010 International Continues		_				Alia las	
	1		30. Name and address of person wh	E, CONN			0619		411/104	
	C Second		Connie Le M.D.	-			un Cont-	o 300 900	oure.	
75	Sta	ite	31. Date filed (Month, Day, Year)	1500 Forest (			-	5, III ZU	110	
	Regist		31. Date filed (Month, Day, Year)	2004 32. Hygistrar's Signat	13	Spork.	2/			

		For State Registrar		State	of Man	yland / i		artment of hartificate of				giene Reg. No.	200	Ļ	14581
V		Decedent's Name (First	t, Middle, Las	it)							2. Date of De Month	ath Day	y Yea		. Time of Death
Physi /Med		Maria	Ma	rgari	ta	Mer	ide:	Z			April		2004		2247 <sup>M</sup>
Exam		4a. Facility Name (If not in	nstitution, give	street and no	umber)	-		4b. City, Town,				4c.	County of De		
	2	Shady Gro						Rockv			1		Monto		
Funera Directo		5. Social Security Number		8x □ M 2 <b>汉</b> F		In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bir (Month, Da 4 – 21 –	у, <sub>Уваг)</sub> 1940	9. E	Country)	(State or Foreign alvador
p >		Usual Residence of Dece 10a. State 10b.	County		1	Oc. City, Tow	m or Lo	cation						10d.	Inside City Limits
anyla shov	7		ntgom	erv	,			rsburg							1 ☐ Yes 2X No
the N	ect	10e. Street and Number						10f. Zip Code				10g. Cit	izen of What	Country?	?
th with the Marylan 23s or 28s-f show ust be notilized at	ā	138 Bowsp	irit	Court					0877	7		El	Salv	ado	r
death ms 23	Funeral Director	11. Marital Status		12. Was De	cedent Ev	er in U.S.	13.	Was Decedent of I	Hispanic (	Origin? (Sp	ecify Yes or No	j.	14. Race - A		
after after or ite	Ē	1 Never Married	2 Married	Armed F 1 ☐ Yes If Yes, G	2 No			1X Yes 2□ No			riican, sto.,		Specify: W		
ours ours	d by	3 XWidowed 4 □ 0	Divorced	Year or	Dates:				El	Śalv	ador				
filed within 72 hours after death with the Maryland Hygiene. Hygiene at the maryland sther than "naturel", or items 23a or 28a-f show ent, the Maryland Examinat must be notified at	Completed		Decedent's Ed by highest gra	ducation de completed	)	16a	(Give	dent's Usual Occu kind of work done DO NOT use retire	durina m	ost of work	ring	16b. K	ind of Busine	ss/indust	try
within ene. then	E G	Elementary/Secondary  O	(0-12)	College	(1-4or 5+)			Homemak	,			Ow	n Hon	ne	
Hygin Hygin The The The The The The The The The The	ပိ	17. Father's Name (First,	Middle, Last)						18. Mo	ther's Nam	e (First, Middle	, Maiden	Sumame)		
ld be ental ked c	To Be	Deliderio	Hern	andez	•				Ar	ntoni	a Mend	dez			
shou and M mar	-	19a. Informant's Name/F						ng Address (Stree							
and 2		Dominga Me	endez/	Daugh	ter			Bowspi	rit						
es 1		20a. Method of Disposition		Removal fron	n State	20b. Place of cemete	of Dispo	nsition (Name of matory or other pla	3 <i>ce)</i>		Date		n Vic		
Pag Iment	>	`4 □Donation 5 □		1		San	Vic	ente	4	/24/			Salv		
permit. Pages 1 and 2 should be filed within 72 hours after deal popariment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any njugger other traumatic event, the Medical Examination	300	21. Signature of Funeral	Service Licer	und	,		P 9	Name and Addr HILIP D 241 Col	RIN.	NALDI La Bi	FUNEI	RAL Lver	SERVI Spri	CE,	P.A. MD20910
	5	23a. Part1. Enter the dis	sease, or com	plications that	caused the	ne death. Do	not en	ter the mode of dy	ing, such	as cardiac	or respiratory a	rrest.		Int	proximate erval Between
Physicia	n	Immediate Cause (Final disease or condition		Acu	1		· CAV	-dial	In	Sano	tion-			0	nset and Death
/Medic	al	resulting in death)		Due to	o (or as a	consequence	of):					-			
Examine	П.	Sequentially list condition if any, leading to immed	ns,	b	. France		-10								
ed isit	nine	if any, leading to immed cause. Enter Underlying Cause (Disease or injury	late	D08 (	U (UI dis ci i	const quance	017.								
xecut and	Xan	that initiated events resulting in death) Last		c. Due t	o (or as a	consequence	of);								
siciar siciar b buri	ical Examiner			d											
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is, F.C. BOX 00100, res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pred		23c. If yes, c		pregnancy  Fetel deat	h 3[	∃Ectopic pregnanc	су				23d. Date of Month	delivery Da	y Year
e deal	sici	in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pre 9□Uni		me of death	5 (	Other (specify)					To the state of th		,
hat the day t	Phy	Part II. Other significant	t conditions of	contributing to	death but	not resulting	in the u	inderlying cause g	ven in Pa	rt I.	23e. Did 1	obacco	use contribute	e to the c	ause of death?
The COLORS, F.C. BOX 00100,  The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	ò p										1 🗀	Yes 2	□No 3□	Probably	y 4 ⊟ <del>Un</del> known
w requir been si should	ete										24a. Was	an	24b. Were	autopsy	findings available
The law	Completed	-									auto	psy ormed?	death	to compli 1? 'es 2E	findings available etion of cause of
	a)	25. Was case referred to	medical	Ι					26. Pla	ace of Dea	1 ☐ Yes	2 ☐ No one)	) '''	95 ZE	3 140
S S T	0	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1	] Inpatient	2 PERVO	utpatie	nt 3 DOA	thor	-	ome 5 Res		6 ☐Other (S	pecify)	
	1	27. Manner of Death	☐ Pending	28a. Dat (Mo	e of Injury		Time o	of 28c. Inju	ury at ork?		28d. Describe	how inju	ry occurred		
Attending death ctor: Atte y the func	19	2 Accident	investigatio						]Yes 2	□No					
or Attending after death Director: A te fune in by the fune	ertification:	3 ☐ Suicide 6	determined	286. Pla	ce of Injur Iding, etc.	y - At home, i (Specify)	farm, si	reet, factory, office	•		28f. Location ( City or To			Hurai He	oute Number,
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	edical C		Certifying Pl Medicel Exe	miner: On the	basis of e	xamination a	ge, dea ind/or in	th occurred at the evestigation, in my	lime, date opinion, d	and place, death occur	, and due to the rred at the time,	cause(s date an	and manner d place, and c	as state	ed. e cause(s)
o the ithin 2 o the	Med	one) 29b. Signature and title	of certifier	anu ma	anner state			29c. Licer	nse numbe	er e		29d. Da	ite signed (Mi	onth, Day	y, Year)
# ≯ F 8		N. D.	MAN	Shori	10	mo		030	697	9		0-	£ 2 . 1	7.	2004
1		30. Name and address	of person wo	completed ca	use of dea	ath (Item 23a	) (Туре	Print)	7.7		2	4			30840
		Deburnh 3	5. Shier		NO O	1901	Me	dical C	ente	400	- ROU	KU:	117,511	Cin	20820
26	State	31. Date filed (Month, D	ay, Year)	104	. Registrar	's Signature	4	Ann 10	21				•		
Reg	istrar	APR	Tare	NT A	A Part			pure la color	4						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [ ] [ ] Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1339 M Year **Physician** Halon Gregory 6 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F N/A Director April 2004 Maryland 16, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 1 No Funeral Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 120 Emily Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gregory Warren Martin Crystal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (father) Gregory Warren Martin 120 Emily Drive, Salisbury, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory April 19,2004 Salisbury, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association
Sol Snow Hill Road, Salisbury, Maryland 21804 Kitt Klerrey 501 Snow Hill Road, Salisbury, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** remoturi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (because of injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospitel or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 129410 04 MAD 223 Phillip Mollis Dr. Salisbury ma distrar's Signature & Sports ss of person who completed cause of death (Item 23a) (Type, Print) MO

DHMH 17 Rev 1/2001

State Registrar 32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month 1135 **Physician** 5h 184 Dawn 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Vicomico 5,4436WM ROGIONM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 P Director N/A Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a, State ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🖔 No Salisbury Wicomico Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 120 Emily Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: þ White 3 Widowed 4 Divorced "netural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Turley Crystal Gregory Warren Martin ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21804 permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other treu once. 120 Emily Drive, Salisbury, Maryland (father) Gregory Warren Martin 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State April 19, 2004 Salisbury, Maryland Salisbury Crematory 1 4 □ Donation 5 □ Other (Specify) <sup>22. Name and Address of Facility</sup>
Holloway Funeral Home Professional Association
501 Snow Hill Road, Salisbury, Maryland 21804 21. Signature of Funeral Service Lices Keelf OC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) remeturity Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this carriffness has a few formers of the funerel Director. burial-transit Due to (or as a consequence of): Box 68760. by Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day for in the past 12 months?
1 \( \text{Yes} \) 2 \( \text{No} \) No 5 Other (specify) 4 Pregnant at time of death P.O. detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, page 2 should be 1 ☐ Yes 2 🗹 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 🗆 Yes 1 Yes of Vital 26. Place of Death (Check only one) the funeral director, 25. Was case referred to medical examiner? Be Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural Certification: Division Injury 5 Pending 1 Tyes 2 🗌 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie cal (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or. Floud (Frau 223 Phillip ) Morris Dr. Salisbury mo Floyd 32. Registrar's Signature Day, Year) 31 Date filed (Month. State APR 2 0 2004 Registrar

For	State	of Marylar		ertment of He		nental Hygi	ene2 (	) () L	14581
<ul><li>State Registrar</li></ul>			Cer	tificate of D	eath	Re	g. No.		
1. Decedent's Name (First, I	fiddle, Last)					2. Date of Death Month	Day	Yeer	3. Time of Death
M/	RGARET	в. м	AGISTR	I		APRIL	11,	2004	11:10 A M
a. Facility Name (If not inst	tution, give street and n	umber)		4b. City, Town, or I	ocation of Death		4c. Count	y of Death	
RANDOLPH	HILLS NURS	ING HOME	E	WHEAT	ON		MONT	GOMER	Υ
. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
197-50-9211	1 ☐ M 2 📉 F	95	Yrs.	January Says		DEC. 7,	1908		À.
Isual Residence of Decede									
Oa. State 10b. Co	unty	10c. Ci	ity, Town or Lo	cation				1	0d. Inside City Limits
MD. M	ONTGOMERY			SILVER SP	RING				1 <b>X</b> Yes 2 □ No
0e. Street and Number		•		10f. Zip Code		10	g. Citizen of	What Cour	ntry?
12502 A	THERTON DR.			2	0906		11.	S.A.	
1. Marital Status		cedent Ever in U	J.S. 13, V	Was Decedent of His	panic Origin? (Sp	ecify Yes or No-	14. Ra	ce - Americ	
1 Never Married 2	Armed F			f Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)		ck, White,	
3 Widowed 4 □ Div	If Yes, C	Sive		I∐Yes 2X No	Specify:		Speci	fy: WHI	тг
	edent's Education		16a Decor	dent's Usual Occupat	ion	1	6b. Kind of I		
(Specify only i	ighest grade completed	d)	(Give	kind of work done du DO NOT use retired)		ring			,
Elementary/Secondary (0	12) College	(1-4or 5+)		HOMEMAK	ED.			HOME	
	delle di anni					e (First, Middle, M	nidan Suma		
7. Father's Name (First, Mi	JUIH, LASI)				IS. MOUTE S INATI	e (i iist, ivildale, ivi	alderi Surria	11107	
FRA	NK S	CHMIDT			T	HERESA	RA	USHER	
9a. Informant's Name/Rela	tionship (Type, Print)		19b. Mailir	g Address (Street ar	nd Number or Rui	al Route Number,	City or Town	, State, Zip	Code)
DOLORES M.	FINUCAN/DA	UGHTER	12502	ATHERTO	N DR., S	ILVER SP	RING,	MD. 2	.0906
Oa. Method of Disposition			Place of Dispo	sition (Name of natory or other place		Date 2	Oc. Location	- City or To	wn, State
1 ☐ Burial 2 🛣 Crema  3 4 ☐ Donation 5 ☐ Oth		n State		·		-2004	RIVERI	ATE	MD
21. Signature of Funeral Se		G		. Name and Address		-2004	VT A EVI	و خاملا	FID •
1 9/10//	Il am bill	A way	CH	AMBERS FU	NERAL HO	ME & CRE	MATORI	UM,P.	A.
1. J. C	<i>funceu</i>			01 CLEVEL				D. 20	
23a. Part1. Enter the disea shock, or heart failure	e, or complications that List only one cause or	t caused the dea neach line.	th. Do not ent	er the mode of dying	such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	FND	STAGE 1	DEMENTI	Α					YEARS
esulting in death)	a	o (or as a consec							2.44110
Sequentially list conditions, f any, leading to immediate	b. Due t	o (or as a consec	quence of):						
cause. Enter Underlying	<	200							
hat initiated events resulting in death) Last	C. Due t	o (or as a consec	nuence of)-						
,	Due (	0 (01 43 4 0011380	quence on.						
	d								
IE EEMALE:	·						1	1	
IF FEMALE: 23b. Was decedent pregna	1 1 1 ive	outcome of pregn		Ectopic pregnancy				ate of delive	
in the past 12 months? 1 Yes 2 No	4 <u>□</u> Pre	gnant at time of		Other (specify)			М	onth	Day Year
9 ☐ Unknown	9□ Unl	rnown							
art II. Other significant co	nditions contributing to	death but not res	sulting in the u	nderlying cause giver	n in Part I.	23e. Did toba	acco use cor	tribute to th	ne cause of death?
-				-		1 ☐ Yes	2 🗆 No	3 ☐ Prob	ably 4 KUnknow
						24a. Was an autopsy		Were auto	psy findings available mpletion of cause of
						perform 1 ☐ Yes 2-	ad? No	death?	2 No
25. Was case referred to m	edical				26. Place of Deat	h (Check only one			
						,, 5/10	-		7-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1
examiner? 1 ☐ Yes 2 🙀 No	Hospital:	Inpatient 2	ER/Outpatien	t 30 DOA Other	A Nureina H	me 5 🗆 Resider	CO 6 170	her (Chack	v)

**Physician** /Medical Examiner

**Physician** /Medical

Examiner

Director

Completed by Funeral

Be 2

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 1/2 from a area.

Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural" or Items 23e or 28e-f ehow any injury or other traumatic event, the Mexical Exercities marked by inclined at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Examiner Medical Certification; To Be Completed by Physician/Medical

27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide 4 ☐ Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

D09834

5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

APRIL 12, 2004

X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARRAGOT AVE., KENSINGTON, MD. 20895 **BARRY** ROSENBAUM, M.D. 3720

State Registrar

31. Date filed (Month Day Year) APR 13 2004

32. Registrar's Signature

outes!

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9,2004 April **Physician** Efigenia Morales 9:03P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Laurel Regional Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 577-86-4622 1□M 2 F 93 2/19/1911 Colombia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Burtonsville MD Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20866 USA 3415 Greencastle Road Items 23e death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ŽNo If Yes, Give 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 0 1⊠Yes 2□No Specify: Colombian Baltimore, Maryland 21215-0036 White þ 3 ₩ Widowed 4 Divorced "neturel", Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than. College (1-4or 5+) Elementary/Secondary (0-12) Own Home permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other the eny injuy octother traumatic event, Ila once. Homemaker n 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sylvestre Morales Delfina Cruz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20904 19a. Informant's Name/Relationship (Type, Print) 11653 Lockwood Drive #202 Silver Spring, MD Jorge Morales/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 StBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 4/16/04 Silver Spring, Md \* 4 □Donation 5 Other (Specify) 21. Signature of uneral Service Livery ee PHILIP ACT RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma of colon /Medical Due to (or as a consequence of) **Examiner** Respiratory failure Sequentially list conditions Examiner Due to for as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed use as the burial-transit Arteriosclerotic cardiovascular disease resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) JYes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 certificate 1 Yes 1 ☐ Yes 2 ☐ No 2X No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🛮 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ZNo 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di this 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dav. Year) 29b. Signature and title 29c. License number D13671 April 12,2004 completed cause of death (Item 23a) (Type, Print) B.G.Manejwale MD. 14201 Laurel Park Drive Laurel, Md 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **APR 15** Registrar

**ORIGINAL** 

			1 - For State Registrar	State of Marylan	d / Depa	artmer	nt of Heal te of Dea	th and M	ental Hy	gienez ()	04	14586
5.	Physici /Medio		1. Decedent's Name (First, Middle, Las. Pilar Maja	ano De Ma	rtine				2. Date of Dea Month April	13,20	Year 0 0 4	3. Time of Death $4:56p^{M}$
	Examin	er	4a. Facility Name (If not institution, give Washington Adve 5. Social Security Number 6. Se	entist Hospi x 7. Age (In yrs.		Tal			8. Date of Birt (Month, Da	Mont	gome	ery  place (State or Foreign ntry)
	Director		215-11-2097   15 Usual Residence of Decedent 10a. State   10b. County	10c. Cit	Yrs. y, Town or Lo		Days	urs Mari,		/1928	El S	Salvador  Od. Inside City Limits
	ith the Mary or 28a-f sh	Director	10e. Street and Number		delph	10f. Zi	Code 0783			10g. Citizen of E1 Sa		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If itam 27 is marked other than "neturel", or itame 23a or 28a-f show apportant: If itam 27 is marked other than "neturel", or itame 23a or 28a-f show any injury or other traumatic event, the Medical Example multiple and once.	y Funeral Director	9100 Adelphi Ro  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Dece If Yes, spe	dent of Hispani cify Cuban, Me	ecity:		14. Ra Bla Speci	ce - Americ ick, White,	can Indian, etc.
Maryland 21215-0036	within 72 hour ane. than "neturel' ne Medical Ex	Completed by	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)	ucation	(Give	dent's Usu kind of w DO NOT U	lal Occupation ork done during use retired)		lvador	16b. Kind of E	Business/In	
yland 2	buld be filed wental Hygie arked other attle event, It	To Be Co	6 17. Father's Name (First, Middle, Last) Andres Majano				18. A	ctavi	(First, Middle, a Core	Maiden Suma a	me)	
	and 2 shi salth and n 27 is m er traum		19a. Informant's Name/Relationship (T Amad > Martinez	/Son	22	16 C	harles	ton P	lace H	yattsv	/ille	
Baltimore,	t. Pages 1 arment of He rtant: If item		20a. Method of Disposition  1  Burial 2  Cremation 3    4  Donation 5  Other (Specific	Removal from State De	Place of Disponder	ratogy of Be i on	other place)	4/19		Mora 2 El Sa	zan, alvad	dor
Bal	Depar Impor any ir		21. Signature of Funeral Service Con-	lK	9:	241		oia Bl	vd.Sil	ver Sp	RVICE	Md20910
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Hemmorha  Due to (or as a consequence of the consequence)  Due to (or as a consequence)  Due to (or as a consequence)	gic S uence ot): athy			ar da car diac o	respiratory an	631,		Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Cause (Disease or injury that infitted events resulting in death) Last	Cirrhosis  Due to (or as a conseq  Heratitis	uence of):							
.O. Box	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	⊒Ectopic p ⊒ Other (s					ate of deliver	ery Day Year
Records, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	_	_	inderlying	cause given in F	Part I.		bacco use con		ne cause of death?
al Rec	The ate ha	e Completed	25. Was case referred to medical					Dia	24a. Was autop perfor 1  Yes	sy med? 2 No	Were auto prior to con death? 1  Yes	psy findings available mpletion of cause of
of Vital	Physicien: this certific al director,	To Be	examiner? 1 ☐ Yes 2 ☑ XNo	1	ER/Outpatie		OA Other: 4[	☐ Nursing Hor	ne 5 Resid	ence 6 Oti		y)
Division o	ath. or: After	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe h			il Route Number,
Div	To the Hospital or Atternation 24 hours after de To the Funeral Directe completely filled in by the	i Certif	4 Homicide determined	building, etc. (Specification)	(v)				City or Tow	n, State)		
	he Hos in 24 hc he Fun pletely	ledical		iner: On the basis of examina and manner stated.		vestigation	n, in my opinion	, death occurre	ed at the time, o	date and place,	and due to	the cause(s)
	Veithin Com	N	29b. Signature and title of certifier  30. Name and 1 dress of person who of	ompleted cause of death (Item	n 23a) (Type,		c. License num	147	7	29d. Date signe	id (Month)	Day, Year)
	Sta	ate	Dr. Nasmen Kango 31. Date filed (Month, Day, Year)	MD 7610 C	arrol	1 Av	4	oma Pâ	rk,Md	20912	. I.	
	Regist	rar	ΔPR 1.5 200	4 Duran	S	apo	und					

		•	For State Registrar	,	State of Ma	arytani	Cei	tifica	te of l	Death	Mentai	Reg. I	165 0 0 th	14587
	Physicia	an	1. Decedent's Name (F	First, Middle, Last)	Mc Corm	n a le					2. Date Monti Apri		<sup>Day</sup> 2004 Year	3. Time of Death 12:15 A M
	/Medic Examin	al	4a. Facility Name (If no			ack		4b. Cit	y, Town, or	Location of Dear			4c. County of Dea	
	Examin	EI	Casey Ho	_	,				Rockv	ille		1	ontgomer	
	Funeral Director		5. Social Security Num 084-24-762	6 111	7. Ag	9 (In yrs. I 71	ast birthday) Yrs.	If Und Month	er 1 Year Days	If Under 24 Hrs Hours Min	8. Date (Mont	of Birth Day, Ye.	9. Bin 932 Nev	hplace (State or Foreign Juntry) W York
	land ow		Usual Residence of De 10a. State 10	ob. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	e Man	ctor	Maryland 1	Montgomer	у	Ro	ckvill	Le						1 AYes 2 No
	vith the	Director	10e. Street and Number					10f. 2	ip Code	- 1		10g.	Citizen of What Co	ountry?
	eath v	Funeral	1515 Dunst		. Was Decedent	Ever in U.	S. 13.1	Was Dec	208		Specify Yes	or No-	USA	rican Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examiner must be notified at once.	by Fun	1 Never Married 3 Widowed 4 [	2 Married	Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:				ecify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	to Rican, etc	.)	Black, Whit	
2-00	72 hou nature	eted		5. Decedent's Educa only highest grade			16a. Dece	lent's Us	ual Occupa	ation furing most of wa	orkina	16b	. Kind of Business	Industry
121	within ene.	Completed	Elementary/Seconda		College (1-4or 5	+)				furing most of wo ) lic Pri		Ro	man Cath	olic Church
ld 2	illed Hygie other	a l	17. Father's Name (Fir	rst, Middle, Last)						18. Mother's Na	me (First, M	iddle, Maid	len Sumame)	
ylar	Duid be Menta Marked	To B	John Mc C							Sheila				
Maryland 21215-0036	nd 2 sh lth and 27 Is m traum	F	19a Informant's Name Joseph A. Pastoral (	Ranieri/(	o, <i>Print)</i> Coordinat	tor,	19b. Mailir	-					y or Town, State, 2 • 20017	Zip Code)
Baltimore,	of Hea		20a. Method of Dispos			20b. P	lace of Dispo emetery, cren	sition (N	ame of other plac	21	Date	_	Location - City or	Town, State
im	Page ment lent: If		`4 □Donation 5		moval from State	1	e of H	eave	n Cen	1. April	1 13, 004	Si1	ver Spri	ng, MD
Ball	permit Depart Import any in		21. Signature of Fune	nal Service Licensee	lass		22	. Name	and Addres	ss of Facility De 2222 W Washing	evol r iscons gton,	unera in Av D.C.	1 Home N.W. 20007	
4	Physician		23a. Part. Enter the fock, or heart fock, or heart focks are condition	ailure. List only one	ations that caused cause on each li Metasta	10.	n. Do not ent	er the m	ode of dyin	g, such as cardia	c or respirat	ory arrest,		Approximate Interval Between Onset and Death Months
	/Medical Examiner		resulting in death)	C a.	Due to (or as									
	Lammer	- a	Sequentially list condi if any, leading to imme	tions, b.	Colon C			_						Years
	outed id ansit	Examiner	Cause (Disease or injuthat initiated events	ury c.										
60,	tificate be executed by physicien and as the burial-transit	ai Exe	resulting in death) Las	st	Due to (or as	a consequ	uence of):							
68760,	tificate I ig physi as the b	ledicai		d.										
Вох		an/M	IF FEMALE: 23b. Was decedent pr	regnant	c. If yes, outcome 1 ☐ Live birth			Ectopic	pregnancy				23d. Date of del	•
.O. E	at the dea by the at tached fo	Physician/M	in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of de	eath 5	Other (	specify)				Month	Day Year
٩	gned be de	by	Part II. Other significa	nt conditions contr	ributing to death b	ut not resu	ulting in the u	nderlying	cause give	en in Part I.				the cause of death?
Records,	w requir been si should	ompleted									24a.	Was an	24b. Were au	stopsy findings available
Re	The lav	omo										autopsy performed	prior to death?	completion of cause of
Vital	ician: certifical rector, p	BeC	25. Was case referred examiner?	177					Lou	26. Place of De	ath (Check	nly one)		
of \	Phys	L.	1 ☐ Yes 2 🐴 No 27. Manner of Death	)	spital: 1 ☐ Inpatie 28a. Date of Inju		ER/Outpatien 28b. Time of			4+5 Indising i			6 □Other (Spenigury occurred	cify)
	Attending r death.  • ctor: After by the funer	ation		5 Pending investigation	28a. Date of Inju (Month, Da	ý Year)	Injury	М	28c. Injun Work	(? Yes 2 □No			,,	
Division	ial or Attendi s after death. al Director: A ed in by the fu	Sertification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str	eet, facto	ory, office			on (Street r Town, St		iral Route Number,
	To the Hospital or within 24 hours after To the Funeral Direcompletely filled in b	edical C	29a. Certifier 1] (Check only 2[ one)	Certifying Physical Medical Exemine	cian: To the best er: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurre estigation	d at the tim on, in my op	ne, date and place pinion, death occ	e, and due to urred at the t	the cause ime, date a	o(s) and manner as and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and titl	e of certifier	10	,		2	9c. License				Date signed (Monti	
	15		) 6	- 1.	Lib-				D09	9470		Apı	ril 7, 20	04
	•		30. Name and address Eugene P.						Kens	ington,	MD 208	395		
	Sta	ite	31. Date filed (Month,		32 Registe				200 1/2					

Mc Cormack

BRENdan

FATHER

		for State Registrar	State of Maryland	d / Depa <i>Cer</i>	irtment of H tificate of I	lealth and N Death		giene Reg. No.	004	1458	8
Obvojsi	4	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day	Year	3. Time of Deat	n A4
Physici: /Medic			Grath			. I time of Donath	April		004 ounty of Death	2:35 p	- M
Examin	er	4a. Facility Name (If not institution, give str. 8101 Connecticut A			Chevy Ch	r Location of Death			ntgomer		
Funeral	2	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		place (State or For	əign
Funeral Director			<sup>4 2□ F</sup> 81	Yrs.	Months Days	Hours Min.	Dec. 2	7, 19	22 Mir	nesota	
p .		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	cation					10d. Inside City Lin	nits
laryla shov	5	MD. Montgomery		y Cha						1 □ Yes 2 🔯	No
the N 28a-f	ect	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	intry?	
3e or	0	8101 Connecticut A	ve. #208N		20815			USA			
ife, Marylatiu Z IZIO-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Mudical Examinar must be nutilified at	/ Funeral Director	1 Never Married Married	. Was Decedent Ever in U.S Armed Forces? 1 ☐¥es 2 ☐ No WWII If Yes, Give	L	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐Mo	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Amer Black, White pecify: W		
hours urai',	d by	3 Widowed 4 Divorced	Year or Dates:	16a Docos	dent's Usual Occup	ation		16b Kind	of Business/I	ndustry	
n 72 In	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Give	kind of work done	during most of wor	king	100.11110	0. 500000	idudity	
i withii iene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Attor	ney			Law			
d be filed antal Hyg ced other c event,	Be C	17. Father's Name (First, Middle, Last)	_			18. Mother's Nam	•	Maiden St	umame)		
Menta Menta Menta Menta Menta Menta Menta	ToE	Thomas J. McGrat	h			Alice Ke					
VIETY JELLU Z I Z I Z I Z I Z I Z I Z Should be filed within 2 h and Mental Hygiene. 7 is marked other than 7 traumatic event, the Median I I I I I I I I I I I I I I I I I I I		19a. Informant's Name/Relationship (Type			-	and Number or Ru					16
t and 2 Health Hem 27 Sther tra		Rosalie McGrath/wi 20a. Method of Disposition			sition (Name of natory or other place		Date		Cnase:	Md. 208 own, State	13
permit. Pages 1 am Department of Heali Importent: if item 2 any injury or other		1 StBurial 2 ☐ Cremation 3 ☐ Rei	moval from State			1 7/		C = 1	C	MD	
permit. Pages Department of Mportent: If it Inyinjury or once.	-	<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licenses</li> </ul>			Heaven_Ce  Name and Addre				r Sprin	nc.,5130	_
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		1 mg 85 =		Wi	sconsin /	Ave., NW.	.Washin	eton '	D.C. 20	)016	
		23a. Part1. Enter the are ase, or complications, or heart ailure. List only one	ations that caused the death	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Cancer of th							Onset and Death  2 months	1
/Medical Examiner		resulting in death)	Due to (or as a consequ								
CXAIIIIIIei	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):							
ted nsit	nine	Cause (Disease or injury	220 to (or as a consequ	.01100 01).							
execu n and ial-tra	Examine	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):							
S& / 6U, icate be executed physician and s the burial-transit	dical	d.									
rtifica ng ph	Medi	IF FEMALE:									
. BOX b8 / b0, death certificate be executed e attending physician and id for use as the burial-transit	hysician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnanc	у		23	d. Date of deli- Month	very Day Year	
at the dea by the a	ysic	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	eath 5L	Other (specify) _						
that the ed by detac	۵.	Part II. Other significant conditions cont	ributing to death but not rest	alting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	e contribute to	the cause of death	?
COTGS, P w requires that been signed to should be deta	d by						10	Yes 2□	No 3□Pro	bably 4 🛭 Unkno	nwc
Hecords, P The law requires that Ite has been signed b age 2 should be dele	Completed						24a. Was		24b. Were au	opsy findings avail	able
The law	E						perfo	rmed? 2K No	death? 1 ☐ Yes	ompletion of cause	
Vital H sician: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?			Lou	26. Place of Dea	th (Check only o	one)			
99	2	1 Yes 2 X No	28a. Date of Injury	ER/Outpatier 28b. Time o	II 3 DON		lome 5 🙀 Resi 28d. Describe			ify)	_
ding R ding R h. After funer	ion	27. Manner of Death  1   Matural  5 ☐ Pending investigation	(Month, Day Year)	Injury	₩o	rk? ]Yes 2 □No	200. 00001100				
Division of Vita to Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, st			28f. Location ( City or To		Number or Ru	ral Route Number,	
Division  To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical Ce		ician: To the best of my kno er; On the basis of examina and manner stated.								
To the vithin To the complex	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date	signed (Month	, Day, Year)	
10		1 (5/11/7	and)		D0060	0653		Apr	il 15,	2004	
1-		30. Name and ad ress of person who cor									
$\gamma$		Thomas M. Loughney					gton, D	200	16		
St	trar	31. Date filed (Month, Day, Year) APR 1 6 20	04 32. Registrar's Signa	ture &	Span	h					

Susan McGraw

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

)4- \KC	-2423 <del>3</del>		1. For unpend ite	State 23a,27,28	of Maryla F,FFR M	nd / Dep <b>,6831</b> _5∕	artment	of H	ealth a	and M	lental Hy	giene	200	L	14589
	Physic /Medi		Decedent's Name (First, Mid	ddle, Last)	P. McG						2. Date of De Month April	eath Day		Year	3. Time of Death
	Examir		4a. Facility Name (If not institu	tion, give street and i	number)		4b. City, 7	Town, or	Location of	of Death	1 2101 IL		County o	f Death	10.52 F
			14000 Castle	Boulevard	Apt. 9	00			Spr			M	lontg	omer	v
	Funeral Director	C	5. Social Security Number 214–94–8695	6. Sex 1 ☐ M 2 🖺 F		. last birthday) Yrs.	If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da Sept. 2	rth		9. Birthp	lace (State or Foreign
	pus		Usual Residence of Decedent 10a. State 10b. Cour	ntv	10c C	ity, Town or Lo	cation							1	0d. Inside City Limits
	/anyla	ō												'	1 ☐ Yes 2 🖾 No
	289-	Director	Maryland Mont	gomery		Silver	Sprin 10f. Zip		-			10a Citi	zen of Wi	nat Cour	atry?
	with 30 or		14000 Castle I	31vd. #900				904					ted S		,
	ma 2	Funeral	11. Marital Status	12. Was De	ecedent Ever in U		Was Decede	ent of His	spanic Ori	gin? (Sp	ecity Yes or No		14. Race	- Americ	an Indian,
980	be filed within 72 hours after death with the Maryland hat Hygiene. Id Hygiene. Id other than "natural", or Itema 23e or 28e-f show event, I've Medical Exeminer must be notified.	b	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☑ Divord	larned 1 Tye	Forces? s 2 <b>]</b> No Give Dates:		llYes,speci 1∐Yes 2		Specity:	i, Puerto	Rican, etc.)		Black, Specify:	, White, Whi	
20	72 ho	Completed	15. Deced	lent's Education hest grade complete	d)		dent's Usual			t of work	ina	16b. Ki	nd of Bus	iness/Inc	dustry
21	thin 7	npie	Elementary/Secondary (0-12		(1-4or 5+)	life.	kind of worl DO NOT us	retired)	unng mos	t of work	ing				
2	filed withi Hygiene. Ither then	S		4		Sec	retar					1	dical		fice
pu	should be filed within of Mental Hygiene. marked other than matic avent, I'm M	Be	17. Father's Name (First, Midd								First, Middle		Sumame,	)	
ž	should be and Mental I is marked o	2	Frederick T.			401 14 37		10.			ia McGr				
Ma	d 2 sl th and 7 is r traur		19a. Informant's Name/Relation Frederick T. S								ille, M				
é,	1 an Heal tem 2		20a. Method of Disposition	pani/rath	20b.	Place of Dispo	sition (Nam	e of			Date I		cation - C		
lo L	ages ant of mt: If I		1 ☐ Burial 2 ☒ Cremation 1 ☐ Donation 5 ☐ Other		m State 1	cemetery, crer ntgomery	-	,	·   F	Apri 200	111,				ryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important; if Item 27 is marked any injury or other traumatic avonce.		21. Signature of Funeral Servi												lle, Inc. 1850-2805
			23a. Part 1. Enter the disease, shock, or heart failure. L	or complications tha	t caused the dea								.ie, r	4D 2C	Approximate Interval Between
0,	Physician and whisician and hysician and potential transit.	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due t	o (or as a consect o (or as a consect o (or as a consect	quence of):	n_								Onset and Death
8760,	ate be nysicia he bu	dlcai		d											
.O. Box 68	ne death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	outcome of pregn b birth 2 ☐ Feta gnant at time of a cnown	al death 3	Ectopic pre Other (spe				=11**	2	3d. Date of Month		ry Day Year
<u>α</u>	res that the igned by be detact		Part II. Other significant cond	itions contributing to	death but not res	sulting in the u	nderlying ca	use givei	n in Part I.		23e. Did t	obacco us	se contrib	ute to th	e cause of death?
rds	requires een sign hould be	d by									10	Yes 2	<b>√</b> No 3	☐ Proba	ably 4 Unknown
Division of Vital Records,	has b	ompleted											prio	or to con ath?	osy findings available appletion of cause of
ita	tician: Th certificate rector, pag	Be C	25. Was case referred to medi examiner?	cal				-	26. Place	of Death	(Check only o			103	2810
Ž	. i	2	1 X Yes 2 No	Hospital: 1	Inpatient 2	] ER/Outpatien	t 3 🗆 DOA	Other	r: 4 □ Nui	rsing Hor	me 5 ☐ Resid	dence 6	Other	(Specify	At scene
n o	ding Ph th, After th funeral	ë.	27. Manner of Death 1 ☐Natural 5 ☐ Pen	28a. Dat ding <b>four</b>	e of Injury hth, Day Year)	28b. Time of	28	c. Injury Work	at ?	2	28d. Describe I		occurred		
Sic	Attending r death, ector: After by the fune	cat	2 ☐ Accident inve 3 ☐ Suicide 6 🕱 Cou	d not be	<b>V</b> 04	2:15 p			es 2 <b>X</b> 1		unknown				
Ξ	i Sirie	ertification;		mined 286. Plai	ce of Injury - At hiding, etc. (Special	fy)	eet, lactory,	office		1	281. Location (3	Street and vn. State	Number Yarlev	or Rural and.	Apt. 900
_	Hospital or Atten 24 hours after deat Funeral Director: stely filled in by the	O	29a. Certifier 1 ☐ Certif	ying Physician: To the	l: residen		L accurred a	the time	data ass	T	Silver S	rrino	Mont	oche	ov.(o. M)
	Hos Fur ely	edicai	(Check only 2 Medic	al Examiner: On the	basis of examina	ation and/or inv	estigation, i	n my opi	nion, deat	h occurre	ed at the time,	date and	place, and	d due to	the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certi		1/1 1		29c.	License	number			29d. Date	signed (i	Month, E	Day, Year)
}	1/		£ 941/	An	VV		0	.C.M	I.E.			Apri	19,	200	4
)	V		30. Name and address of person	on who complete to a	use of death (Iter	п 23а) (Туре,		Dann	C+~						d 21201
	Sta	te	31. Date liled (Month, Day, Yea		Registrar's Signa	ature 🔏	-	_		CCL,	ווויזדמת	ME,	ricit.)	A TOLY	u CICUI
	Registr		APR 1	2 2004	Serena	P	papa	uls							

		-	Ragistrar	State of Maryland	/ Depa	rtment of He tificate of De	Juli	uea	ene 2001	
	Physicia		Decedent's Name (First, Middle, Last)     MARVIN JERRY MENSH					2. Date of Death Month APRIL 9,	Day Year 2004	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, give so SHADY GROVE ADVENT	reet and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday).	If Under 1 Year   I	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	thplace (State or Foreign buntry)
	iand ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f ehow imst be notified at	ctor	MARYLAND MONTGOMER	Y GAITI	HERSBU	IRG				1 ☐ Yes 2 🕅 No
	or 28	Directo	10e. Street and Number			10f. Zip Code			7. Citizen of What Co	ountry?
	eath v	Funeral	110 CHEVY CHASE STR	2 Was Decedent Ever in U.S.	. 13. V	20878 Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spec		. S . A .	erican Indian,
	hours after di tural', or Itam al Examinat	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1		Mexican, Puerto F Specify:	ican, etc.)	Black, White	
215-003b	be filed within 72 hours after death with the Marylan ital Hygliene death with the matural; or itams 23a or 28a-f show other than "natural; or itams 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	ent's Usual Occupation kind of work done dur NOT use retired)	on ring most of workin	g	b. Kind of Business	/Industry
7	filed will Hygien other th		12 17. Father's Name (First, Middle, Last)		SELF I	EMPLOYED	8. Mother's Name		RETAIL	
and	nould be fit Mental H narked ott	o Be	MARK	MENSH			HELMA	(1 1/3t, Wildard, Wil	KARLIN	SKY
Maryland	should ind Men s marke umatic	2	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street and		Route Number, (	City or Town, State, 2	Zip Code)
	and 2 ealth a n 27 is		BARBARA MENSH/WIFE			HEVY CHASE				
ore	Pages 1 nent of Hu ant: If iter		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Reference    Burial 3 □ Ref	emoval from State	netery, cren	sition (Name of natory or other place)			C. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic engoes.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			EM. GARDEN Name and Address DWARD SAGE		and the same of th	LNEY, MAR	ILAND
<u>n</u>	8 8 E 8		Materio		10	91 ROCKVI	LLE PIKE	, ROCKVI	LLE, MARY	LAND 20852
H			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final				such as cardiac or	respiratory arres	τ,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque	Sh	ock				UNKNOWN
# <sub>1</sub>	Examiner		Sequentially list conditions							
No.	sit	lner	Sequentially list conditions.  If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ince of):					
	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
8760	te be ( ysiciar	dical								
9		Med	IF FEMALE:	3c. If yes, outcome of pregnan	cv				22d Date al de	lh.o.
.O. Box	at the death certifi by the attending I tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	death 3	Ectopic pre <i>g</i> nancy Other <i>(specify)</i>			23d. Date of de Month	Day Year
<u> </u>	The law requires that the site has been signed by th bage 2 should be detache	ρ	Part II. Other significant conditions con	tributing to death but not result	ting in the u	nderlying cause given	in Part I.		cco use contribute to	o the cause of death?
00e	e law req has beer je 2 shou	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ž		Com						performe	ed? death? No 1 ☐ Yes	
Vita	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	D/Outpotion	t 3 DOA Other:	26. Place of Death		ce 6 □Other (Spe	raife)
Division of Vital Records,	ding Phys h. After this funeral di	<del> </del>	27. Manner of Death 1 Statural 5 Pending		28b. Time of Injury	28c. Injury a Work?	4   Nursing Flori	8d. Describe how		kairy)
Divisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)		eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital within 24 hours. To the Funeral completely filled	Medical C	29a. Certifier Certifying Physical (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	rledge, deatl on and/or in	occurred at the time vestigation, in my opin	, date and place, a nion, death occurre	nd due to the cau d at the time, dat	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the To the To the Comple	Me	29b. Signature and title of certifier	. 1		29c. License r			d. Date signed (Moni	
	45	)	Kristnijadi	entouremo			05 487	r	April 7,	2004
1			30. Name and address of person who co	mpleted cause of death (Item:	23a) (Type,	Print) nedical Ce	enter Tri.	re Rock	cuite m.	aryland
	Sta	ate	31. Date liled (Month, Day, Year)	32. Registrar's Signatu	ire 4	load	1	C 700		
	Regist		APR 1 4 200	14 penera	10	paparkas				

			1 - For State Ragistrar	Sta	ite of M	arylan	d / Depa <i>Cei</i>	artmen <i>tificate</i>	t of H e of i	lealth a Death	and Me		giene Rag. No		4	4591
	Dhusisi		1. Decedent's Name (First, Middle	, Last)							2	Date of Dea	ath Day	y Ye		Time of Death
	Physici /Medio		DEBBIE			ILLER						APRIL		2004		55 P M
	Examir	er .	4a. Facility Name (If not institution					7.		Location of	of Death			County of D		
			5225 POOKS HILI  5. Social Security Number	ROAD,			ast birthday)	BE'	THES		24 Hrs. A	. Date of Birt	h	1ONTGO		State or Foreign
	Funeral Director		218-58-8631	1 ☐ M 2		52		Months	Days	Hours	Min.	EPT I	у <sub>Уваг)</sub> 3, 19	951 V	IRGIN]	State or Foreign
	σ		Usual Residence of Decedent													
	aryiar ahow	<u>.</u>	10a. State 10b. County	OMERNIA		10c. City	, Town or Lo									side City Limits  Yes 2 No
	he M	Director	MARYLAND MONTG	OMERY			BETHE	SDA 10f. Zip	Codo				10a Cit	izen of What		Y 103 2 110
	with a or		5225 POOKS HI	T.T. ROA	D #1	129 N		TOI. ZIP		20814			-			F AMERICA
	death ms 23	Funeral	11. Marital Status	12. Wa	s Decedent	Ever in U.		Was Deced			gin? (Speci	fy Yes or No- can, etc.)		14. Race - A	American Ind	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or Itams 23a or 28a-f ahow marke other than "natural", or it en marke my filed by matter and the my filed by the market of the my filed by the market of the my filed by the market of the my filed by the market of the my filed by the my file	by	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 [	ned Forces? ]Yes 2 🔼 'es, Give ar or Dates:			fYes,spec 1⊡Yes 2		Specify:		can, etc.)		Black, V Specify:	Vhite, etc. WHITE	Ε
Ö	72 hou	Completed	15. Decedent (Specify only highes		oletad)		16a. Dece	ient's Usua	al Occup	ation	t of working		16b. K	ind of Busine	ess/Industry	
215	ithin 7	nple	Elementary/Secondary (0-12)	<del>-</del>	llege (1-4or	5+)	`life.	DO NOT us	se retired	dining mos ()	COT WORKING					
7	filed w Hygier othar th		47 Fabrus Mana (Fina Middle	()	4		REAL	TOR		10 14-15-	-d- M (	F* 48*-4-4		SE SA	LES	
and	ba fi	Be	17. Father's Name (First, Middle, JOSEPH MILLER	_ast)								First, Middle, DLENSK		Sumame)		
Ž	should ind Men a marka umatic	ဥ	19a. Informant's Name/Relationsh	nin <i>(Tvna Pri</i>	int)		19h Mailir	a Address	(Street			Route Numbe		r Town Stat	e Zin Code	)
<u>8</u>	and 2 s saith an n 27 la lar trau		ROBERT MILLER -		•				•			NE, PO				
ē,	s 1 ar f Hea item othar		20a. Method of Disposition			20b. P	lace of Dispo	sition (Nan	ne of		Dat			ocation - City		
altimore,	Pages nent of I		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Si	3 □Remova <i>ecify)</i> MAU	I from State SOLEUN	- 1		-	,		04/1	13/04	RO	CKVILI	LE, MA	RYLAND
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic es one.		21. Signature of Funeral Service I	icensee								DIREC				
			23a. Part! Enter the disease, or	complications	s that cause	d the death						ROCK espiratory ar		E, MD	Appro	oximate
b	Pnysician		shock, or heart failure. List Immediate Cause (Final				DOTTC	CADDT	.01740	OUT AT	D DICE	EACE			Onse	val Between et and Death
	/Medical		disease or condition resulting in death)	_	Due to (or as		ROTIC uence of):	CARDI	UVAS	CULA	K DISI	LASE			- 6 M	IONTHS
g	Examiner		Sequentially list conditions	b												
	p tis	Examiner	Sequentially list conditions, any, leading to in rediata cause. Enter Underlying Cause (Disease or injury	- 2	ue to (or as	a consect	isnes of):									
	ecuts and I-trans	xam	that initiated events resulting in death) Last	c	Due to (or as	a consequ	ience of):									
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687	ficate g phys	edlcal		d												
Вох	eath certific attending p	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		es, outcome			Totalia.						23d. Date of	delivery	
m .	death	sicla	in the past 12 months? 1 □ Yes 2 X No	4	]Live birth ]Pregnant a ]Unknown			Ectopic pro Other (sp						Month	Day	Year
P.O.	that the de ad by the a detached	hys	9 Unknown													
	98	by	Part II. Other significant condition  AMEMIA	ns contributir	ng to death b	ut not resu	ulting in the u	nderlying ca	ause give	an in Part I.	•			ise contribute		se of death?
ord	w require been si	eted	ZMILATILI									-		ANO 3	Probably	4 DUNKNOWN
3ec	has b	Completed										24a. Was autop	sy	24b. Were prior death	to completic	dings available on of cause of
a E												1 Yes	2 No	1 🗆 \	Yes 2⊠N	lo
₹	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospita	l: . Oleven		<b>FD</b> (0		Othe			Check only of				-
ō	Fa the	H 1	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a	. Date of Inju (Month, Da		ER/Outpatier 28b. Time of		8c. Injury	/ at		5 X Resid			specify)	
O	ttanding F death. :tor: After the funera	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	9	(Month, Da	y Year)	Injury	М	Work	c? Yes 2.∐!	No					
Division of Vital Records,	for Attane after death Diractor:	Certification;	3 Suicide 6 Could r 4 Homicide determ		. Płace of Inj building, et	ury - At ho c. (Specify	me, farm, str	eet, factory	, office		281	Location (S City or Tow	treet an n, State	d Number or )	r Rural Route	e Number,
ш	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune		29a. Certifier 1 Certifyin (Check only 2 Medical													ause(s)
	tha H hin 24 tha F nplete	Medical	one)		id manner st		1/	-								
i .			29b. Signature and title of certifler	1/	///	11	Shr	290		number 11921				e signed (Me		cdI)
1	(0		9	ye	-V 63	CC C	72017	Dain'	υ.	11741			APR]	IL 12,	2004	
			JOHN A. GALOTTO						AD -	#1A	BETHE	SDA, M	D 2	20814		
	Sta	te	31 Date filed (Month Day Year)		32. Registr				ark.							
	Registi	21	APR 14	2004	Ber	was	P	just	A STATE OF A							

			For Stete - Stete Registrer	tate of Ma	•	artment of H			iene2001	14592
	Pĥysici	an	1. Decedent's Name (First, Middle, Last)  Melvin Moxley					2. Date of Death Month April 8	h Day Yea	
	/Medic Examin		4a. Facility Name (If not institution, give stree Gilchrist Center	at and number)		4b. City, Town, or		APITI 0	4c. County of De	8:25 A M
825Am	Funeral Director		5. Social Security Number 403–44–6074 12 M		(In yrs. last birthday	Baltimore  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 13	<sup>y</sup> ear) 9. B , 1936 Ke	irthplace (State or Foreign Country) ntucky
85	aryland ehow	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits  X Yes 2 □ No
7	death with the Maryland ms 23a or 28a-f ehow	Directo	Maryland Howard  10e. Street and Number		Columbia	10f. Zip Code		10	ng. Citizen of What	Country?
418104	Baltimore, Maryland 21215-0036 parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if time 27 is marked other then "neturel; or Itams 23a or 28a-f ehow any injury or other treumatic event, the Medical Exercitivative redified at once.	Funeral Director	77	Was Decedent E	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian,
17	hours aft	þ			955-1959	1 ☐ Yes 2 况 No	Specify:	1	Specify:	Black
in	aryland 21215-0036 2 should be filed within 72 hours af and Mental Hygiene, an marked other then "neture!, or sumatic event, the Medical Exerci-	Completed	(Specify only highest grade co		(Giv life.	e kind of work done o DO NOT use retired,	luring most of worki )	ng		t of Labor
Je lu	rland halfle file fental Hygurked otheric event,	To Be C	17. Father's Name <i>(First, Middl</i> e, <i>Last)</i> Wilford Moxley				18. Mother's Name Helen Wo		faiden Sumame)	
5	Mary and 2 sho alith and A 27 is ma		19a. Informant's Name/Relationship (Туре, Sandra Moxley- Wife	Print)		ing Address <i>(Street a</i> 5 Macomber			-	, Zip Code)
Moxley, Melvin	Baltimore, parmit. Pages 1 ar Department of Hes mportent: If item any injury or otha once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Remo  4 □ Donation 5 □ Other (Specify)	oval from State		osition (Name of ematory or other place name of Mem. Par	9)		ockville,	
Nox	Bafti parmit. Departn Importe any inje		21. Signature Funeral Service Licensee	ih_		22. Name and Addres				al Home ing, MD 20904
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one or immediate Cause (Final disease or condition resulting in death)	ause on each lin	the death. Do not ere.  Net A Sta- consequence of):	ter the mode of dying	g, such as cardiac o		est,	Approximate Interval Between Onset and Death
	be exacuted be exacuted be exacuted be burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate outs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):		= =			
	Records, P.O. Box 68760, The law requires that the death certificate be exacuted the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		If yes, outcome o	of pregnancy	Cetopio programa			23d. Date of d	lelivery
	P.O. Be that the death after detached for	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
	cords, P w requires that been signed t should be det	by	Part II. Other significant conditions contrib	uting to death bu	t not resulting in the	underlying cause give	in in Part I.			to the cause of death?  Probably 4 Dunknown
	I Reco	Completed						24a. Was ar autopsy perform 1 🗆 Yes 2	y prior to ned? death'	autopsy findings available o completion of cause of ? as 2 \( \text{No} \)
	on of Vital F ding Physicien: Th th. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	1 L Inpatier			4   Nursing Hor	ne 5 🗌 Reside	nce 6 Other (Sp	pocity) Hospice
	Division of Vital Records, To the Hospital or Attending Physicien: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be	Certification;	2 Accident investigation 3 Suicide 6 Could not be	8a. Date of Injur (Month, Day 8e. Place of Inju	ry - At home, farm, s	M 1 🖂	res 2 □No	28f. Location (Str		Rural Route Number,
	Divisit To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	ai Certi	4 ☐ nomicide  29a. Certifier 1⊠ Certifying Physicia	building, etc	f my knowledge, dea	th occurred at the tim	e, date and place, a	City or Town	use(s) and manner	as stated.
_	To the Ho within 24 h To the Fu	Medical	(Check only 2 Medicel Examiner: 29b. Signature and title of certifier	On the basis of and manner sta	examination and/or ited.	nvestigation, in my op			ete and place, and d	
	10		30. Name and address of person who compa	g // leted cause of de	(Item 23a) (Type	D25	205	<i>F.</i>	tpril 8,	2004
0	St	ate	W.A. Riley G	Bruc	6701 N	1. Charle	, St. Ba	lto m	d 2120	>
	Regist		31. Date filed (Mark Day Year) 2004	Spren	m B	spark	/			

Amend Item Please Type or Print in Black Indelible in the Copies Are Legible.

For AMEND#5 4/21/04 State of Maryland / Department of Health and Mental Hygiene? For AMEND#5 4/21/04 State Registrar AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Gregory P. Machelski PRIL 154 M 200 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deat Examiner JLEN BURNIE MNE RUNDEL 20 JORTH JUNDE 5-50cial Security Number 570-52-5787 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 28, 6 Sex (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 51 Yrs. Director ΤX Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at MD Anne Arundel Pasadena 1 ☐ Yes 2 🙀 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 613 Eliot Road 21122 USA "natural", or items 23a Funeral GREGORY 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo White 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: by Specify: 3 ☐ Widowed 4 Ki Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry rthan Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene Tool & Dye Maker Wave (Armstrong) 12 other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pe is marked Richard Machelski Lorraine Kalisz MACHELSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Machelski/Brother 17 North Carolina Avenue, Reading, PA item 27 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Apr. 19, 2004 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite ö 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses <sup>22</sup> Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home nomus Hen 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of pring such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Complications of chronic alcoholism Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-trae CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ó 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 page certificate 1 Yes 2 No 2 No 1 Yes or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes . 25 ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Medicai Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death 1 Tyes after death

Director: A

d in by the f 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide in 24 hours. the Funeral Direction of the Fune Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi To the 29b. Signature and the of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 KU SUM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 9-2004

			1 - For State Registrar	State of Ma	aryland / D	epartm Certific	ent of F	lealth and I Death		giene' Rog. No.	2004	14594
	Physic	ian	Decedent's Name (First, Middle, Last	st)					2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medi		Nancy	L.			orton		Apr.	8,	2004	7:15 p M
4000	Examir	ner	4a. Facility Name (If not institution, give			4b. 0	-	r Location of Deati	h	4c. (	County of Death	
			Chesapeake Hospic  5. Social Security Number 6. S		(In yrs. last birth	rday) If U	Li:	nthicum   If Under 24 Hrs.	8. Date of Birt		Inne Aru	
	Funeral Director		-	□M 2∏F	77.77	rs. Mon		Hours Min.	(Month, Da)	, Year)		place (State or Foreign ntry)
	76		Usual Residence of Decedent						Jul. 3,	1926	)	
	how	L	10a. State 10b. County DE Ker	nt-	10c. City, Town	or Location	70.70					10d. Inside City Limits
	Ba-f s	cto		ic.		.00	VEL					1 ☐ Yes 2√∑ No
1	23a or 2	al Director	10e. Street and Number 101 Upland Avenue	2		10f	. Zip Code 1	9901		10g. Citiz	en of What Coul	ntry?
0500-61212	De liled within 72 hours after death with the Maryland hall Hygiene. do other than "natural", or items 23a or 28a-f show event, the Musical Exertifier must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		If Yes,	ecedent of H specify Cuba s 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		4. Race - Americ Black, White, Specify:	
<b>ှ</b>	natur	ted	15. Decedent's Ed (Specify only highest gra		16a. [	Decedent's t	Jsual Occup	ation during most of wor	rking	16b. Kin	d of Business/In	dustry
7	9 9 9	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NO	T use retired	1)	_	Uni	ted Stat	ces
7	ygier ygier har th	S	12		Ac	dminis	strati	ve Assis		- Charles Ville	Force	
	B E P S	Be	17. Father's Name (First, Middle, Last) Nolson M. Staats					18. Mother's Nan Blanch	ne (First, Middle,	Maiden S	Sumame)	
7	is 1 and 2 should be 1 feath and Mental 1 item 27 is marked o other traumatic eve	은			401		- 12					
	nd 2 sr lith and 27 is n r traun	1	19a. Informant's Name/Relationship (1) Henry Nelson Mor	**				and Number or Ru " Lothia:		r, City or 0711	Town, State, Zip	Code)
บ์ .	Tand Health em 27		20a. Method of Disposition	Coay was	20b. Place of D			, sacreter	Date		ation - City or To	own State
Dallillore,	permit. Pages Department of Important: If its any injury or o		1 🔀 Burial 2 🗆 Cremation 3 🗔		cemetery,	, crematory	or other plac		. 12,		yrna, DE	•
	artme ortani injury	1	* 4 □ Donation 5 □ Other (Specify 21. Signature * Fun ral Service Licen		Odd Fe			CTY ss of Facility	_2004		7-13-17 320	
ם ו	any pen		1 thomas	5 D//1-		Barr	canco	& Sons, 1	P.A. Sev	erna	Park Fu	meral Home
	W.		23a. Part1. Enter the disease, or comp	olications that caused	the death. Do no	t enter the	mode of dyin	Ritchie I g, such as cardiac	or respiratory ari	erna. est,	Park, M	Approximate
	hysician /Medical Examiner		shock, or heart failure. List only inmediate Cause (Final disease or condition resulting in death)	a. Meta	stasic E consequence of		Cance	r				Interval Between Onset and Death
Ži.	* -	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a	i consequence of	) <del>.</del>						
don't conficult to consume	icale be executed physician and s the burial-transit	al Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of	):						
	p phy:	edical		. d								
, to the design of the second	by the attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1	2 Fetal death	3 □Ectopi 5 □ Other	c pregnancy (specify)			23	d. Date of delive Month	ory Day Year
- 6	ad by detac	P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in t	he underlyir	ng cause givi	en in Part I.	23e. Did to	bacco usi	e contribute to th	ne cause of death?
GCOIDS,	as been signed by th 2 should be detache	ted by										ably 4 Dunknown
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1	ate h page	Con							perfor	ned? 2√2 No	death?	•
loien.	certificate has t	Be (	25. Was case referred to medical examiner?			7		26. Place of Dea	th (Check only or			
5	this	ation: To	1 ☐ Yes 2 🔀 No  27. Manner of Death 1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 ☐ Inpatier  28a. Date of Injury (Month, Day)	v 28b. Tin	ne of	DOA Other	4 🗆 Nursing 🗆	ome 5 Reside			Hospice House
ital or Attending	rs after death. ral Director: After	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm (Specify)	n, street, fac	tory, office		28f. Location (Si City or Town	reet and n, State)	Number or Rura	l Route Number,
No Hoen	within 24 hours af To the Funeral D completely filled in	edical	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o liner: On the basis of and manner stat	examination and/	death occur or investigat	red at the tim tion, in my op	ne, date and place, pinion, death occur	, and due to the c red at the time, d	ause(s) a ate and p	nd manner as st lace, and due to	ated. the cause(s)
1	withi To the	ž	29b. Signature and title of certifier				29c. License		2		signed (Month, L	-
			maren	~ O. W	elter	V	D23	143			April 9	, 2004
~			30. Name and address of person who o				-					
/_	197-		Martin Weitz, MD	7525 Gr	eenway C	ourt 1	Drive,	Greenbe	lt, MD	20770	)	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 5	32. Redistra	r's Signature	Loon	di s					

		For State Registrar  1. Decedent's Name (First, Middle, Last,		Certificate of Death	2. Date of De Month	Reg. No. 2001	3. Time of Deat
Physici: /Medic	al	Graham Abbott Mars  4a. Facility Name (If not institution, give		4b. City, Town, or Location	April	17, 2004 4c. County of Dea	3:15 A
Examin uneral	eı	Sunrise Assisted L 5. Social Security Number 6. Se	iving - Bestga		r 24 Hrs. 8. Date of Bi	Anne Arun	thplace (State or For
Moul		579-07-4208  Usual Residence of Decedent  10a. State		y, Town or Location	May 1,	1920 Vir	ginia 10d. Inside City Lir 1∑Yes 2□
28e-f a	Director	Maryland Anne Arun  10e. Street and Number	der Amal	oolis		10g. Citizen of What Co	
Department of recent and workers by growing in a transfer of them 27 a not 28e-1 show any injury or other traumatic event, it a Medical Examenar must be notified at angle.	Funeral DI	922 Berwick Drive  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 (X) No	If Yes, specify Cuban, Mexico	rigin? (Specify Yes or No an, Puerto Rican, etc.)	Black, Whit	erican Indian, te, etc.
stural', or	þ	3₩ Widowed 4 Divorced  15. Decedent's Edu	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify  16a. Decedent's Usual Occupation		Specify: W	
than "na	Completed	(Specify only highest grad	completed) College (1-4or 5+)	(Give kind of work done during mo life. DO NOT use retired)  Builder	st of working	Self Employ	v <b>e</b> d
ced other	Be	17. Father's Name (First, Middle, Last) Harold Cameron Mar		18. Mot	ner's Name (First, Middle		,
mar	F	19a. Informant's Name/Relationship (T		19b. Mailing Address (Street and Num		er, City or Town, State,	Zip Code)
If item 27 I		Dianne M. Hood / D 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐	Removal from State	922 Berwick Drive lace of Disposition (Name of emetery, crematory or other place)	Date	Maryland 2 20c. Location - City or	Town, State
Important: any injury ance.		* 4 □ Donation * 5 □ Other (Specify, 21. Signature of Fune all Service Liver	fa d	22. Name and Address of Fac	John M.	Paltimore, I	ral Home,
attending physicien and led ica and led ica as the burial-transit	ilcal Examiner	23a. Part1. Enter the decase, or comp shock, or heart failure. List only of the shock of the sho	Due to (or as a conseq to Due to Due to Due to (or as a conseq to Due to Due to Due to Due to Du		s cardiac or respiratory a	irrest,	Approximate Interval Between Onset and Deat
the	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 Ectopic pregnancy		23d. Date of de Month	olivery Day Year
5 8	ρ	Part II. Other significant conditions of	ntributing to death but not res	ulting in the underlying cause given in Par		tobacco use contribute to	o the cause of death robably 4 DUnkn
certificate has been sig rector, page 2 should b	Completed				1 ☐ Yes	opsy prior to death? 2 No 1 Yes	utopsy findings avai completion of cause s 2 \( \subseteq \text{No} \)
this al di	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of feath	Hospital: 1 ☐ Inpatient 2 ☐	Other	oe of Death (Check only  Nursing Home 5  Res	-1	ASS 151
am. e: After ne funei	Certification:	Natural 5 Pending investigation  Suicide 6 Could not be determined	(Month, Day Year)	Injury Work?  M 1 Tyes 2 ome, farm, street, factory, office	□No  28f. Location	(Street and Number or Rown, State)	Residl Tural Route Number,
within 24 hours after de To the Funerel Directic completely filled in by it		29a. Certifier X Certifying Ph	vsician: To the best of my kno	owledge, death occurred at the time, date attion and/or investigation, in my opinion, d			
To the F	Medical	29b. Signature and title of certifier	and manner stated.	29c. License numbe		29d. Date signed (Mon	
		30. Name and address of person who	completed cause of death //ter	m 23a) (Type, Print) /	12]	7,1	000
	6.0	Soll manipular additions of bollson Hills	Col	KT 1/ Ja 101 - 1	1 1	#1010/00	west 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Margaret DeVaux Munday State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Margaris 16 2004 10 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or For Months | Days | Hours | Min. | Sept. 25, 1911 | California 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 551-70-3604 1 ☐ M 2 🔀 F Months 92 Director Usual Residence of Decedent with the Maryland ahow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Itam 27 is markad other than "natural", or Itams 23a or 28a-f ahov othar traumatic avant, the Modical Engriner must be notified at Maryland Funeral Director Anne Arundel Gambrills 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 1706 Justin Drive United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. hours after ☐ Yes 2 🛣 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 35 Widowed 4 ☐ Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Delbert DeVaux Rose Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a 1706 Justin Dr. Gambrills, MD. 21054 Walter L. Munday, III (son) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cametery, cramatory or other place)
Chesapeake
Cremation Center or other place) 1 ☐ Burial 2XXX remation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD. 118, 2004 21. Signature of Fune at Service Licensee 22. Name and Address of FacilityAdams Funeral & Memorial M00982 Care 814 Bestgate Rd. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 1500019 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medlcal the use a JE FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 200 1 Yes 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Inpatient 2 EN/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To tha Funaral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 Y Yez 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7175 10000 Hansi- CT

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mon

ORIGINAL

gistrar's Signature

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	State of Maryland / Department of Healt	h and Mental Hygier	ne 2 O
For	State of marytame, population of the		7 0
_ State	Cortificate of Dog	th	2000

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of	Health and N Death		ene 2 0 0 L	14597
	Physici /Medic		1. Decedent's Name (First, Middle, L Robert Me	*				2. Date of Death April 1	, <sup>Day</sup> 2004 Year	3. Time of Death 10:50 PM
	Examir		4a. Fecility Name (If not institution, gi 45995 East Sunri	,		Lexing	or Location of Death		4c. County of Dea St. Mary	's
	Funeral Director		161-18-2816	Sex 12M 2□F	e (In yrs. last birthday 85 Yrs.	Months Days		8. Date of Birth (Month, Day, ) December 5	(ear) 9. Bir Co 5, 1918 Pen	thplace (State or Foreign ountry) nsylvania
	a-f show	ctor	Usual Residence of Decedent  10a. State  Maryland  St. Mar	y's	10c. City, Town or Lexingt	ocation on Park				10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	Funeral Director	10e. Street and Number 45995 East Sunri	se Drive		10f. Zip Code 2065.	3	100	g. Citizen of What Co USA	ountry?
920	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23e or 28e-f show event, I'm Medical Examiner must be notified at		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, Whi Specify: W	
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed by	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of world)	king	nited Sta	
and 2	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Las Lester Merritts	it)			18. Mother's Nam Vera Kot	ne (First, Middle, Ma		
Mary		7	19a. Informant's Name/Relationship Karen Joyce Rich	(Type, Print) er/Daughte	19b. Ma r 51 La			ral Route Number, C ield, MA	City or Town, State, .	Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tra once.		20a. Method of Disposition  1			ematory or other pla			oc. Location - City or eltenham,	
Balti	permit. Pages i Department of H Importent: If ite any injury or of once.		21. Signature of Foneral Service of Muchael Filera	Harden	) M	22. Name and Addr attingley-0 .0. Box 270	ess of Facility Fardiner Fun Leonardtow	eral Home, n, Maryland	P.A. 20650	
	Physician /Medical		23a. Pent1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aCarc	inomatoses		ing, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death Months
	Examiner	Examiner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Lung Due to (or as	a consequence of):  Cancer a consequence of):  a consequence of):					l Year
8760,	cate be executed physician and the burial-transit	dical E		d	<u> </u>					
. Box 6	death certiff e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify)	y		23d. Date of de Month	livery Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	ven in Part I.			o the cause of death?
II Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of 2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0:		th (Check only one)		
	ding Phys After this funeral dir	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju	ry 28b. Time y Year) 28b. Time Injury	of 28c. Inju		ome 5 Residence 28d. Describe how	ce 6 Other (Spe	cify)
Division	of or Attending after death.  Director: After d in by the funer	Certification;	3 Suicide 6 Could not 4 Homicide determine	be 390 Place of Ini	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stree City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospitel or At- within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifying F	Physician: To the best miner: On the basis o and manner st	f examination and/or i	ath occurred at the t nvestigation, in my	ime, date and place, opinion, death occur	and due to the cau- red at the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	Jarlos	MT	29c. Licen	se number 06419	7 290	I. Date signed (Mont	
10	m		30. Name and address of person		e th (Item 23a) (Type		Hollywood	I MD 2063	26	•

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene ? 001

14598

					Certificate of	Death	R	eg. No.	UH	14598
	Physic	an	1. Decedent's Name (First, Middle, Las	it)			2. Date of Deat Month		Vaca	3. Time of Death
	/Medi		JOAN F. MIL	LER				-2004	Year	11:03 AM
فر	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death	4c. County	of Death	
			414 BERRING ROAD			OCEAN CI	TY	WOR	CESTER	₹.
· [	Funeral Director		5. Social Security Number 6. Social Security Number 1 577-44-7092 Usual Residence of Decedent	PX 7. Age (In yrs. last of 9	t birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 8-28-19	Year) 34		ace (State or Foreign ry) JERSEY
death with the Maryland	r 28a-f show	'n	10a. State 10b. County		Town or Location			•	10	od. Inside City Limits
the M	28a-1	ect	MARYLAND WORCEST  10e. Street and Number	ER OC	CEAN CITY					
with	0 %	Pi			10f. Zip Code		1	0g. Citizen of		
eath	r 23a	eral	414 BERRING ROAD	10 Was Decedent Free in U.C.	2184				ED STA	
ours after d	Department or heatin and wental hygiene. Important: If item 27 is merked other than "natural", or Items eny injury or other traumatic event, if a Medical Examiner mone.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Dacedent of If Yes, specify Cut		city Yes or No- Rican, etc.)		ce - America ck, White, el y: WH	
d within 72 hours af	die	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occu	pation	20	16b. Kind of B	usiness/Indu	ıstry
量	e e e	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	ed)	,g			
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d 2 should be file	a di H	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N	faiden Surnan	1e)	
PINC	arke aric	ဥ	CHARLES P. WOOD			BERNAD	ETTE SM	ITH		
2 sh	and is m aum		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Address (Stree	t and Number or Rura	l Route Number,	City or Town,	State, Zip C	Code)
and	n 27 n 27 her tr		TERRI MILLER/ DAU		9004 E. BISC.	AYNE DR.,	OCEAN C	ITY, MI	218	42
es 1	i je		20a. Method of Disposition 1 ☐ Burial 2 NCremation 3 ☐	20b. Place	e of Disposition (Name of	PODEN	Date 2	20c. Location -	City or Tow	n, State
oermit. Pages 1 ar	int: h		4 Donation 5 Other (Specify,		CREMATORY	4	-22-04	FRANKFO	)RD,DE	LAWARE
mit.	Importa eny inju		21. Sign ture of Furnial Vervice Licent	7 1	22. Name and Addre	ess of Facility NERAL SERV	TODO 1	_		
8.8	3 = 5 8		149/10/1	11/2.						
		$\dashv$	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	Do not enter the mode of dvi	OCEAN VIE	w, DE.	19970	1	Annrovimate
Dhy	ysician	01	shock, or heart failure List only o	ne cause on each line.		<b>3</b> ,	noopa.o., a	J.,	İ	Approximate nterval Between Onset and Death
_	ledical		Immediate Cause (Final	Kanal						
	aminer		disease or condition resulting in death)	a.	CACIN	10MA	•			
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certificate be executed	ding physician and ise as the burial-transit	Xa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
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	ned by the attenc detached for us	Physician							1	
he d	ched the	Ş	Part II. Other significant conditions con	ntributing to death but not resultin	g in the underlying cause given	ven in Part I.	23b. Did tob	acco use cor	to ti	he cause of death?
that	ed by deta						1 □ Ye	s 2⊡No	3 Probal	bly 4 ☐ Unknown
Physician: The law requires that the death	5 8	ρ				-			041 144	
redn	been signal	Completed					24a. Was an perform	autopsy ed?	availa	e autopsy findings able prior to
law	20	ᇍ							of de	oletion of cause eath?
	ate ha	ခြု					1 ☐ Yes	2 € No	1 🗆 ነ	Yes 2□ No
Physician:	certifica rector, p	Be (	25. Was case referred to medical examiner?			26. Place of Death	(Check only one	)		
ysic	<u>.∞ .</u>	ၟႄႍ	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER	Outpatient 3□ DOA	ner: 4□ Nursing Hom	e 5 Resider	ce 6 🗆 Othe	er (Specify)	
	도 교		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28	b. Time of 28c. Injury Wor		Bd. Describe how			
Attending or death.	tor: After the fune	atie	✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(World), Day Your)		Yes 2□No				
Atten	Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home	, farm, street, factory, office	28	3f. Location (Stre		er or Rural F	Route Number,
al or A	io io	<u> </u>	4 Difformoide	building, etc. (Specify)			City or Town,	State)		
Hospital 24 hours	Funer tely fill	Medical (	29a. Certifier Certifying Physical Control (Check only one)	sician: To the best of my knowled her: On the basis of examination and manner stated.	ge, death occurred at the tir and/or investigation, in my o	me, date and place, an opinion, death occurred	nd due to the cau d at the time, dat	ise(s) and mer e and place, a	nner as state and due to th	ed. ne cause(s)
To the	To the comple	₹ -	29b. Signature and title of certifier	and market stated.	29c. Licens	se number	29	d. Date signed	(Month Da	v Voarl
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I	<		30. Name and address of person who co					4		
1	)		DR. JOSEPH MCSHEA			LIN, MD. 21	L811			
	Stat	~	31. Date filed (Month, Day, Year)	32. Pegistrar's Signature	Society )					
	Registra	T	APR 2 3 20	104 REMED SO	18 June					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004

14599 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month HELEN J. MARVEL 9:00 AM 4 23 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 32035 SHAVOX ROAD SALISBURY WICOMICO 5. Social Security Number If Under 24 Hrs. Hours Min. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 217-28-4244 1□ M 2□ F Country) MARYLAND Yrs Director 71 6-9-1932 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ed other than "neturel", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 1 No MARYLAND WICOMICO SALISBURY 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 32035 SHAVOX ROAD 21804 UNITED STATES death Funeral 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel, or item any injury or other treumatic event, the Marked of the Marked other. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: WHITE þ Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER WILLIS LONG MARGIE V. BAKER ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA G. BYLER/ DAUGHTER 32035 SHAVOX RD., SALISBURY, MARYLAND.21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEW HOPE CEMETERY 4-28-04 WILLARDS, MARYLAND 21. Signature of Fund 154 MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST., FRANKFORD, DE. 19945 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical porte Examiner Due to (or as a consequence of): Physiclan/Medical Examiner i or Attanding Physicien: The law requires that the death certificate be executed efter death. ettending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? is certificate has been signed by director, page 2 should be detach 1 LYS 2 No 3 ☐ Probably 4 ☐ Unknown \$ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has 1 ☐ Yes 20NO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 14 Natural 5 Pending filled in by the fi investigation 1 TYes 2 TNo 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital
within 24 hours e
To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY, MD 2150) Countil 145 E. CARROLL 9VI Year) gistrar's Signature State 2004 Registrar

DHMH 16 Rev 6/95

			State of Maryland / Dep	partment of Health and Mertificate of Death	/lental Hygi	ene 2004	14600
}	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Charles J. Mol  4a. Facility Name (If not institution, give street and number)  MCTCY MCCUCAL CULER	LOY  4b. City, Town, or Location of Death  BOLLT NEW	2. Date of Death Month APRIL	Day 2004 4c. County of Deeth	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 178-30-5325 125 66 Yrs.		B. Date of Birth (Month, Dey) Feb 3, 1	9. Birth 938 Penn	nptace (State or Foreign Intry) ISYLVania
	within 72 hours after death with the Maryland ene. than 'ratural', or Itams 23a or 28a-f show ha Medical Examinet must be notified at	ector	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or  Maryland Prince George's  10e. Street and Number	Mitchellville	10	g. Citizen of What Co	10d. tnside City Limits 1 ☑ Yes 2 ☐ No
	ath with t	Funeral Director	11609 Chantilly Lane	20721		USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural; or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examination and any injury or other traumatic event, the Medical Examination and any once.	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     □ Yes 2  No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
Maryland 21215-0036	within 72 ho ene. than natur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Cotlege (1-4or 5+)  12th	edent's Usual Occupation ve kind of work done during most of work DO NOT use retired) Salesman	king	6b. Kind of Business/l	
yland 2	should be filed withind Mental Hygiene. I marked other than umatic event, the Mental Control of the Mental of the	To Be C	17. Father's Name (First, Middle, Last) Charles J. Molloy	Anr	ne (First, Middle, M na O'Neil	1	
	and 2 she alth and 127 is m er traum	Í	Diane M. Molloy (Wife) 1160	iling Address (Street and Number or Ru 09 Chantilly Lane,	Mitchell		
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tri once.		1 X Burial 2 I Cremation 3 I Internoval from State 1	position (Name of ematory or other place)  Mem Gardens 4/1		oc. Location - City or Tolly avidsonvil	
Balti	permit. 1 Departm Importar any inju			22. Name and Address of Facility Rer 9013 Annapolis Roa	ndon/Hale	Funeral H	ome
68760,	Physician /Medical Examiner  the private and t	dical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not death of the complete that the cause of the complete that the cause of the complete that the cause of the complete that the cause of the complete that the cause of the complete that the cause (Disease or injury that initiated events resulting in death) Last  23a. Part. Enter the disease, or complications that caused the death. Do not death. Do	inter the mode of dying, such as cardiac		st,	Approximate Interval Between Onset and Death Sugar Tulis
P.O. Box 6	it the death certificate by the attending physic by the attending physic tached for use as the both	Physician/Medi		B ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	very Day Year
	ires tha signed d be de	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
II Reco		Completed			24a. Was an autopsy perform 1 □ Yes 2	prior to death?	topsy findings available completion of cause of
Division of Vital Records,	ding Phy h. After this funeral d	ation: To Be	25. Was case referred to medical examiner?  1	ient 3 DOA Other: 4 Nursing H	th (Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Spec	tify)
Divis	in Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Ptace of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
2	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)				
	To the within To the comp	¥	29b. Signature and title of certifier  ATTENDING	29c. License number DS6399		ARRIL 14,	7. Dey, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type Jeanette Nazarian, M.D. 30]	e.Print) St. Paul Place, E	Baltimore	MD 21202	
7	St Regist	ate rar	31. Date filed (Month, Day, Year)  APR 1 6 2004  32. Registrar's Signature				

		1- For State of Maryland / Department of Certificate of		601
Physi	cian	Decedent's Name (First, Middle, Last)	2. Date of Death  Month Day Year  3. Time of	of Death
/Med		Evelyn Marshall		08 P <sup>M</sup>
Exam	iner		or Locetion of Death 4c. County of Death	
		Southern Maryland Hospital Clinton		
Funera Directo		5. Social Security Number  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Yea  Months Day:  74 Yrs. Months Day:	Hours Min. (Month, Dev. Yeer) Country	or Foreign
		Usual Residence of Decedent	August 4 1929 North Car	olina
yland		10a. State 10b. County 10c. City, Town or Location	10d. Inside C	City Limits
Mar Mar Miled	tor	MD Prince George's Capital Heigh	1 XYes	s 2□No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Mealcal Executive most be notified at mone.	al Director	10e. Street and Number 10f. Zip Code 4202 Urn Street	20743 10g. Citizen of What Country? U.S.A.	
deat	Completed by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Armed Forces? 15. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
after or Ite	F	1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No  If Yes, Give		
DO3	db	3 Widowed 4 Divorced Year or Dates:	Specify: Specify: Black	
72 r	ete	15. Decedent's Education 16a. Decedent's Usual Occi (Specify only highest grade completed) (Give kind of work don	pation 16b. Kind of Business/Industry during most of working add	
<b>12 13 14 15 16 17 17 17 17 17 17 17 17</b>	μ	Elementary/Secondary (0-12) College (1-4or 5+) Web. DO NOT use retirementary 12th Housewife		
d 2 filed v Hygie other i	ပိ	17. Father's Name (First, Middle, Last)	Private	
d be d the d of o	Be		18. Mother's Name (First, Middle, Maiden Sumame)	
arylan should be nd Mental marked c	10		Charlotte Jones	
Baltimore, Maryland 21215-0036 bermit. Pages 1 and 2 should be filed within 72 hours alt bepartment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or my injury or other traumatic event, tra Medical Examples.			t and Number or Rural Route Number, City or Town, State, Zip Code)	
Heal Heal		20a. Method of Disposition   20b. Place of Disposition (Name of	eet Capital Heights, Maryland 207	743
no ages nt of triffil		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other plants	nce)	
Itin		'4 □ Donation 5 □ Other (Specify) Riverdale Cremat  21. Signature of Funeral Service Uensee / 22. Name and Addr	ory 4/17/2004 Riverdale, Maryland	d
Balt permit. Depart Import			over Road Landover, Maryland 2078	35
Physician and physician and the burial-transit	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximation and a cardiac or respiratory arrest,  Approximation and interval Better and Consett and	Death
Records, P.O. Box 6i The law requires that the de: th certific te has been signed by the alterning p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	y 23d. Date of delivery Month Day	Year
IS, P ires that signed b	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gr		
w requir	etec		1 Yes 2 No 3 Probably 4	Unknown
	Completed		24a. Was an autopsy autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 ☑ No	available ause of
of Vital Physician: This certifical	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check only one)	
of ohy this al di	၉	1 Inpatient 2 ER/Outpatient 3 DOA	4 Nursing Home 5 Residence 6 Other (Specify)	
E g g	Certification;	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Wo		
Attending r death.	cat	3 Suidde 6 Could not be	Yes 2 □ No	
Division  I or Attending after death. Director: Afte	i i	4 Homicide  determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Num. City or Town, State)	ber,
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edical Ce	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the transfer of the basis of examination and/or investigation, in my one)	me, date and place, and due to the cause(s) and manner as stated.  pinion, death occurred at the time, date and place, and due to the cause(s)	s)
To the within 2 To the comple	Mec	29b. Signature and title of pertities 29c. Licens		
F ≥ F 8		M + 20	and the signed (in the signed of the signed	
			1580 4-14.04	
(12)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCOT  EMERGENCY MEDICINE 7503 SYRR		35
St Regist	ate rar	31. Date filed (Month, Day, Yeer)  APR 1 6 2004  Live & Signature	CHANGE IN WOLD	-
/		MINERAL AND RECORDED		

ORIGINAL

			1 - For State Registrar	State of Ma	aryland	l / Depa	artmen rtificate	t of H	ealth ar Death			Reg. No.	2004	11000
	Physicia		1. Decedent's Name (First, Middle, Last) Pauline Wilson M	lachen						2	2. Date of De Month April	Day	Year 2004	3. Time of Death 2:45 a
>	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location of	Death			County of Deet	
			Hillhaven Nursing					Ade1	~				ince Go	
	Funeral Director		5. Social Security Number 213-03-0128 6. Sex 1□	M 2 🔀 F	e (In yrs. Ia 86	st birthday) Yrs.	If Under Months		Hours	Min.	B. Date of Bird (Month, Date uly 16,	v. Year)	9. Birtl Co Pen	nplece (Stete or Foreign untry) nsylvania
	pu k		Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or Lo	cation							10d. Inside City Limits
	Maryla f sho	Į.	Maryland Prince	George's			tsvil	le.						1 XYes 2 □ No
	r 28a	irec	10e. Street and Number		L		10f. Zip	Code				10g. Citiz	en of What Co	untry?
	th wit	ai D	7020 Hunter Lane						20782				U.S.A.	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f show sumatic event, the Mardical Exam. In most be notified a	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	2. Was Decedent I Amed Forces? 1 ☐ Yes 2 M I If Yes, Give Year or Dates:			Was Deced If Yes, spec 1 \( \text{Yes} \)		spanic Origin, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)		4. Race - Ame Black, White Specify: Wh	
ş	2 hou satura sal E	ted	15. Decedent's Educ	ation		16a. Dece	dent's Usua	I Occupa	ition	of undia		16b. Kin	d of Business/	ndustry
9500-61212	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2	College (1-4or 5	5+)				luring most o	or working	,			
2	led w lygier ther th	Co	17, Father's Name (First, Middle, Last)			Off	ice Ma			's Name /	First, Middle,			eering Ofc.
anc	d be fi	To Be	Byron J. Wilson						Anna		rnelia			
듄	S D E E	۲	19a. Informant's Name/Relationship (Typ	oe, Print)		19b. Mailir	ng Address	(Street a	and Number	or Rural	Route Numbe	er, City or	Town, State, Z	ip Code)
	Health a Health a Health a Health a to the transition 27 la other transition a to the transition and the transition and the transition are transition and the transition are transitional and the transition are transitional are t		Sarah W. Waller -	Sister					lane,		and, M		0777	
Baltimore,	Pages 1 nent of He int: if Iter iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	Cei	nce of Dispo metery, crea	natory or o	ther place	·	Da			ation · City or	
	it. Pa irtmen irtant: njury		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>	Δ.	Ceda	ar Hil					2004			Maryland
n n	permit. Pages 1 Department of H Important: If Ite eny injury or ot 20028.		Claudette Da		ina	47	739 Ва	iltin	nore A	Gasc	h's Fu e. Hva	ineral	l Home,	P.A. D 20781
4	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury)	Alzhei  Due to (or as	mer's a conseque	Dise		e of dying	g, such as ca	ardiac or	respiratory a	rrest,	3	Approximate Interval Between Onset and Death
. Box 68	at the death certificate be executed by the attending physician and tached for use as the burial-transit	by Physician/Medical Exar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	Due to (or as  Bc. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnan	cy death 3[	Ectopic pr					23	3d. Date of deli	very Day Year
<u>.</u>	that the post of t	y Ph	Part II. Other significant conditions con	tributing to death b	ut not resul	ting in the u	nderlying c	ause give	n in Part I.		23e. Did t	obacco us	e contribute to	the cause of death?
rds	w requires that been signed to should be deta		Hypothyroidism								10	Yes 2⊠	No 3□Pro	bbably 4 Unknown
Records,	The faw requires that the te has been signed by the bage 2 should be detache	Completed									24a. Was autop	osy	24b. Were au prior to death?	topsy findings available ompletion of cause of
	10 57										1 Yes	rmed? 2 🖾 No	1 Yes	2 No
VItal V		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital:	nt 2 🗆 E	:R/Outpatier	* a 🗆 n c	Othe			Check only o		Other (Spec	
	g Physical dispersal dis	H .	27. Manner of Death	28a. Date of Inju (Month, Day		28b. Time o		8c. Injury Work	→ MA IAMIS		d. Describe			ary)
Division	Attendin ar death. ector: Af by the fur	Certification:	1 \( \overline{\textbf{X}}\) Natural 5 \( \overline{\text{Pending}}\) Pending investigation 3 \( \overline{\text{Suicide}}\) Suicide 6 \( \overline{\text{Could not be}}\) determined	28e. Place of Injuding, etc	ury - At hon	injury ne, farm, str	М	1 🗆 Y	r res 2□No		Bf. Location (S City or Tov		Number or Ru	ral Route Number,
_	Hospital 4 hours Funeral iely filled	edical Ce	29a. Certifier 1 A Certifying Phys (Check only one) 2 Medical Exeminate	ician: To the best er: On the basis of and manner sta	f examination	rledge, deat on and/or in	h occurred vestigation	at the tim , in my op	e, date and binion, death	place, an	nd due to the	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Month	, Dey, Year)
1	6		Hill	H.D.				D.	55559			Apri	1 13, 2	2004
R	(10)		30. Name and address of person who co Thomas Maslen, M.D					Driv	e, #3	16, (	Greenbe	elt,	MD 207	770
3	Sta		31. Date tiled (Month, Day, Year)	22. Registr	ar's Signatu	lie has	BI							

**ORIGINAL** 

_			1 - For State Registrar	State of Maryla		artment of I tificate of		lental Hygie	~ ~ U U	4 14603
	Physic /Medi	cal		Morgan				2. Date of Death Month April 10		/:32 p M
	Examir	ner	4a. Fecility Name (If not institution, give Joseph Richey  5. Social Security Number 6. Si	Hospice	s. last birthday)		imore If Under 24 Hrs.	8 Date of Birth		ore City
	Director		218-54-6277 <sup>1</sup> Usual Residence of Oecedent	□ M 2X F 52	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, You Aug. 3,	1951 N	Birthplace (State or Foreigr Country) Iaryland
	th the Marylan or 28a-f show	irector	10e. Street and Number	George's		Carrollt  10f. Zip Code	on	10g	Citizen of What	10d. Inside City Limits 1 ☑ Yes 2 ☐ No Country?
g	72 hours after death with the Maryland Inatural; or Items 23a or 28a-f show dical Examinar must be millied at	Funeral Director	7613 Fountaineble  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No	U.S. 13. V	Vas Decedent of F Yes, specify Cuba	784 lispanic Origin? (Spe an, Mexican, Puerto			merican Indian, /hite, etc.
21215-0036	c _ @	To Be Completed by	3 Widowed 4 Divorced  15 Decedent's Ed (Specify only highest gra	de completed)		ent's Usual Occup	Specify: ation during most of worki	ng 168	Specify:	White ss/Industry
and 212	be fite tal Hy d othe	Be Com	Herbert N. Barni	College (1-4or 5+)		al Corres	Spondent 18. Mother's Name	(First, Middle, Mai		
332 Mary 32	1 and 2 should be Health and Menta em 27 is marked other traumatic ex	To	19a. Informant's Name/Relationship (7 Michael J. Morgan	ype, Print)			and Number or Rura		ity or Town, State	e, Zip Code) 20784
Baltimore	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	For	Place of Dispos cemetery, crem t Lincol	sition (Name of latory or other place n Cemeter	э) 04/14	/2004 Br	: Location - City entwood	or Town, State , Maryland
T Bal	permil Depar Impor any in		21. Signature of Funeral Service Licens  Claudette 2  23a. Part L. Enter the disease, or company to the orthogology to be a service of the se	Dasch Lann	4/	39 Balti	ss of Facility Gas more Aven	ue, Hyatt	ral Hom sville,	MD 20781
0	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Brace. Due to (or as a conse	Diseau		g, such as cardiac o			Approximate Interval Between Onset and Death
(4.) 68760,	icate be executed physicism and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consect  Due to (or as a consect  d.						
O. Box	the death certific / the attending p ched for use as t	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of a 9□Unknown	al death 3 □I	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
rds, P.	The law requires that the death ate has been signed by the atte bage 2 should be detached for		Part II. Other significant conditions co	ntributing to death but not res	sulting in the und	derlying cause give	on in Part I.	23e. Did tobacc		to the cause of death?  Probably 4 □Unknown
borra. Vital Record	The lay	e Completed	25. Was case referred to medical					24a. Was an autopsy performed	prior to death'	
7 5	ding Ph J. After th funeral	To B	examiner?  1 Yes 25 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Othe	at 2			ecity) Hospics
$\mathcal{Q}_{noision}$	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	y) 	et, factory, office	2	City or Town, St.	ate)	Rural Route Number,
	To the Hospital or All within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death a ation and/or inve	occurred at the tim estigation, in my op	inion, death occurre	d at the time, date a	ind place, and di	ue to the cause(s)
	To with con		30. Name and address of person who co	dit. he	n 23a) (Type, P	p 000 g			Date signed (Moi	ш, рау, теаг)
CR	Star Registra		G, William Bank 31. Date filed (Month, Day, Year) APR 1 & 2004	Q CT 6565 2. Registrar's Signa	N. Chen		Bultimore	, mo.	21204	•

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year PETER MORCHO A APRIL 2004 6:40am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 12826 Camellia Drive Montgomery 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□F Director 220-39-9692 60 20, 1943 Cameroon, W.A Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23e or 28a-f show the Medical Exactings must be notified at Md. Montgomery Silver Spring 1 X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 12826 Camellia Drive U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after ariment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or Ite injury or othar traumatic event, Ite Madical Examina 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No à Specify: 3 Widowed 4 Divorced **Black** Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andreas S. Morcho Francisca N. Sama 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Morcho/Wife 12826 Camellia Dr., Silver Spring Md. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) MBU Village Cem. 5/1/04 Cameroon, W.A. 22. Name and Address of Facility Johnson & Jenkins Inc. 21. Signature of Funeral Service Licer 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. detached 9□ Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes > No Other: 2 4 Nursing Home 2 ER/Outpatient 3 DOA 5 sidence 6 Other (Specify) this s Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury death. 1 Tyes 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nancy A. 225, Greene St MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 5 2004 Registrar

**ORIGINAL** 

		1 - For State Registrar	State of Maryla	Cei	trificate of	Death			2004	4605
		Decedent's Name (First, Middle, La	ist)			200	2. Date of Dea	leg. No. th		3. Time of Death
Physicia /Medic		Richard Henry	Mulroo	nev			April	1 9 Day	2004	10:18A M
Examine		4a. Fecility Name (If not institution, gir		iicy	4b. City, Town, o	or Location of Death	•	_	County of Death	12011011
	U	Civista Medi	cal Center		La P1	ata			Charles	
uneral			4 (ST) 4.4	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
rector		209-18-7749 Usual Residence of Decedent	TO WE SUP	79 Yrs.			February	74,	1925 P€	nnsylvania
A II		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
100	ō	Maryland Prince (	Jenraes (	Oxon Hi	1 7					1 ☐ Yes 2 ☒ No
importent, I well 27 is transed other than insular, or items 23s or 25e-1 anow any injury or other traumatic event, the Modical Examiner must be notified at once.	Funeral Director	10e. Street and Number	scorges .	OXOII III	10f. Zip Code		1	On Citi	zen of What Cour	2tn/2
4	0	1512 Colony Ro	oad		20745				SA	tu y :
	era	11. Marital Status	12. Was Decedent Ever in U	J.S.   13. V		Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-		14. Race - Americ	can Indian,
age	Ē	1 Never Married 2X Married	Armed Forces?	$W \perp \perp \perp$			Rican, etc.)		Black, White,	etc.
	è	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2½ No	Specify:			Specify:Whit	e
	Completed	15. Decedent's E (Specify only highest or	ducation ade completed)		ent's Usual Occup	pation during most of working	20	16b. Kir	nd of Business/In	dustry
N N	du.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire	d)		Fod.	omal C	
# ·	S	47 5-4-4-1-4-1	1	Trans	<u>portatio</u>	n Analyst			eral Gov	ernment
•	Be	17. Father's Name (First, Middle, Last Charles				18. Mother's Name	(First, Middle, I			
1	၀		Mulrooney			Marie			McHale	
Iraun	8	19a. Informant's Name/Relationship	, ,	1		and Number or Rura				Code)
The T		Pearl E. Mulroon  20a. Method of Disposition		1512 ( Place of Dispos	Colony R	d., Oxon F				
0		1 Burial 2 Cramation 3	Domoval from State	cemetery, crem	atory or other plac	ce)		20c. Loc	cation - City or To	wn, State
jury	- 1	`4 □ Donation 5 ☑ Other (Special	w Entombmentkes	surrect.	ion Ceme	tery 4/22/	'04 C	lint	ton, MD	
any ir		21. Signature of Funeral Service Lice	1500	Geo	Name and Addre	ss of Facility Kalas Fune Hill Rd.,	ral Hom	e. F	Ρ.Α.	
		23a. Part1. Enter the disease, or com		616	60 0xon I	Hill Rd.,	Oxon Hi	11,	MD 2074	5
cian lical iner inertransit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect b. Due to (or as a consect c. Due to (or as a consect d	quence of):	hcar+	Dise	age			Onset and Death
(V)	an i	IF FEMALE:								
3 3	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ıl death 3 ⊟l	Ectopic pregnancy	,		23	3d. Date of delive Month	ry Day Year
	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	leath 5∟	Other (specify)				WOTH	Day Teal
	5	Part II. Other significant conditions of	ontribution to death but not res	ulting in the un	terlying cause gu	on in Bart I	23a Did tah	2000 110	o contributo to th	e cause of death?
g 3					or, my dadoo gree	on my art.			No 3 Proba	
	ere								1140 3[]11008	ably 4 Dprikriown
V 1	Completed						24a. Was an autopsy	/	24b. Were autop prior to con	sy findings available aptetion of cause of
							perform 1 ☐ Yes 2	No No	1 🗆 Yes	2□ No
0	a	25. Was case referred to medical examiner?	Hospital:		Tau	26. Place of Death	(Check only one	)		
_   r	0	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Linpatient 21	ER/Outpatient		4 Li Nursing Hom				)
	0	1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	ζ?	8d. Describe how	w injury	occurred	
	car	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y) arm, stre	et, factory, office	2	8f. Location (Str. City or Town,	eet and State)	Number or Rural	Route Number,
	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the timestigation, in my op	ne, date and place, and pinion, death occurre	nd due to the car d at the time, da	use(s) a te and p	nd manner as sta place, and due to	ited. the cause(s)
<u>a</u>	MA.	29b. Signature and title of certifier			29c. License	number	29	d. Date	signed (Month, D	Pay, Year)
and in the second	Z -			~~						
complete	Me	· yarin	m. jagan		ח_ ב	0000		Ken.	(19.2	ae4
complete	Me	> yanin				0883	-	Assu	(19.2	ae4
To the Funerel Director: A completely filled in by the fu	Me	N 8	completed cause of death (Item	n 23a) (Type, P	rint)					

			1 - For State Registrar	State of Maryla	•	artmen rtificate				ental Hy	/giene Reg. No	200	4 1460		
190	Physici /Medic Examin	cal	Month Day Year									11:30 N			
	Funeral Director		5. Social Security Number 6. Sex 577-88-4618  Usual Residence of Decedent	7. Age (In y	vrs. last birthday) 42 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D. Feb. 1	irth	9. B	inhplace (State or Foreig Country) tth Carolina		
e, Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if firem 27 is marked other than "natural; or firem 27 is marked other than "natural; or firem 27 is marked other than page. And it is a marked by the Martical Examination of the frontier of the firematic event, the Martical Examination of the firematic of the firematic or other traumatic event, the Martical Examination of the firematic o	by Funeral Direct	10a. State 10b. County  Maryland Prince Geor		City, Town or Lo	1bor					10a Cit	izen of What C	10d. Inside City Limits 11 Yes 2 □ No		
			10603 Tyrone Drive  11. Marital Status 1 □ Never Married 2 Married   12. Was Decedent Ever in U.S. Armed Forces?   13.   13.   1 □ Never Married   2 Married   1 □ Yes 3 Married   1 □ Yes 3 Married   1 □ Ye								Unit	United States  14. Race - American Indian, Black, White, etc.  Specify: Black			
		Be Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)	cion completed) College (1-4or 5+) 2	life.	dent's Usua kind of wor DO NOT us lcare	rk done d se retired	during most vider		ng (First, Middle	Pri	vate  Sumame)	s/Industry		
		ToB					Pearl Tabron  Iddress (Street and Number or Rural Route Number, City or Town, Pryrone Drive, Upper Marlboro, Marlbor						Zip Code) 20772		
			20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Ren  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	savel from Ctata	b. Place of Dispo cemetery, crer ashingto	natory or or on Nat	ther place: 1 (	Cem 4	/23/0	ote 04 uneral	Suit	cland,			
eg E			23a. Part1. Enter the disease, or complica	tions that caused the d	55	38 Ma	rlbo	ro Pi	íke,	Forest	vill	e, MD	20747 Approximate Interval Between		
760,	hy the attending physician and detached for use as the buriat-transit	licai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	jwy	net	2 6	2mpl	icatio	2 1		Onset and Death		
on of Vital Records, P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown							23d. Date of de Month	elivery Day Year				
	quires that n signed b uld be deta	by	Part II. Other significent conditions contributing to death but not resulting in the underly in the Conditions of the Co					ertying cause given in Part I. 23e. Did to					obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
	this certifica	e Completed	25. Was case referred to medical	a p 1 □ Ye				perfo 1 ☐ Yes	prior to completion of cause of death?  1 Yes 2 No						
		To B	examiner?  1 Payes 2 No  27. Manner of Death 1 Natural 5 Pending	A 2	A 28c. Injury at Work? Bw				□ Residence 6 □ Other (Specify)  pescribe how injury occurred  N = & her howard while						
DIVISION	To the Hospital or Attending, within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	0	m, street, factory, office				28f. Location (Street and Number or Rural Boute Number, City or Town, State)						
	To the Hospital within 24 hours and the Funeral completely filled	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medicel Exemine	ien: To the best of my r: On the basis of exam and manner stated.	knowledge, death nination and/or in	occurred a vestigation,	at the tim in my op	ne, date and pinion, deat	d place, a	nd due to the ed at the time,	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)		
)		W	29b. Signature and title of certifier    Signature and title of certifier				29c. License number  ##DOS \$ 5 9 27								
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 3 2004	19, 300/ 32. Registrar's Si	Hospita	10	11)~	-, 0	Der	of,	4 45	nylm	id		

ORIGINAL

OHM 04-2593 NATHAN MILLER

# unpend #2, 27,28a-f,PER ME,C832,6/22/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registra Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 April 08:15 A Nathan Leon Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6001 Muncaster Mill Road Derwood Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | 7/23/37 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Carolina 1**∑**M 2□F 245-60-7879 Yrs. No. 66 Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State or than "natural", or Items 23a or 28a-f show the Medical Examiner must be nutflied at N Yes 2□No Directo Prince Georges Districy Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6307 District Height Parkway 20747 death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: black 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0·12) 12th College (1-4or 5+) Maintenance Federal Govt. permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If Item 27 is marked other tt any injury or other traumatic event. ILA ODG. 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Louise Williams Clyde Miller 19b. Mailing Address (Street and Number of Wall Pout Number, City of Town State, Zip Code) 20747 19a. Informant's Name/Relationship (Type, Print) Olivia Prince/Sister 6307 District Heights Parkway Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dobbins Cemetery 4-24-04 Hamlet, No. Carolina ¹ 4 □Donation 5 □Other (Specify) B K Henry Funeral Chapel Inc. 420 H Street NE Washington DC 21. Signature of Funeral Service Licensee, 20002 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Head injuries with complications Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? page 1 XYes 2 🗆 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence MXOther (Specify) 1√ Yes 2 No 2 SCENE 28a. Date of Injury 12/24/03 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attending 1 Natural 5 Pending hours after death. uneral Director: Aft unknown 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 833 19th St., Apt. #04, N.E., Washington, residence within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

And manner stated.

and manner stated. 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Greenberg MD O.C.M.E. April 15, 2004 Josha 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Tasha Z Greenberg M.D 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 2 7 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 200 L 14608 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Nathaniel Alroy McCray 19, 2004 3:25 P.M. April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 5. Social Security Number If Under 1 8. Date of Birth (Month, Day) 4/3/36 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F 578-48-9862 Yrs Director Wash., D.C. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner roust be notified at Md. P.G. Seat Pleasant 1X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 Carrington Avenue 20743 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Agged Forces? 1 Eyes 2 □ No If Yes, Give Year or Dates: \$55-\$57 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Black þ 3 ☐ Widowed 4 ₺ Divorced "netural', Completed d other than "netur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Will McCrav Ruby C. Rucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other trau William I. McCray/Brother 14121 Franklin St., Woodbridge, Va. 22191 20a. Method of Disposition

X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 4/29/04 Cheltenham, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Wash., D.C. 20019 ana 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mole of dying, such as cardiac or respir lory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last e to for sa consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-Box 68760. Physician/Medicai attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f o 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 2.20(No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha autopsy performes 1 Yes 2 No Division of Vital 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2X No 1 Tes Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manney of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

To the Funeral C

completely filled i Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifile 29d. Date signed (Month, Pay, Year) 1 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) James Catevenis, M.D. 3001 Hospital Drive, Cheverly, Md. 20785 31. Date filed (Month, Day, Year) State APR 2 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 20

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No						-20	40	-	

		Registrar				Ce	rtificat	e of l	Death			Reg. No.		17005
	*	1. Decedent's Name (F	First, Middle, La	ist)							2. Date of D	eath Day	Vane	3. Time of Death
	sician edical		Edward	Marshal	.1						Month Apr	il TE	3 <b>,</b> 2ď%4	8:00 A. M
	miner	4. C Th. March 1 (11	nt institution, giv	e street and nu	ımber)		4b. City,	Town, or	Location	of Death		4c.	County of Deat	
		Prince Geo	rge's F	Hospital	Center			Chev	erly			Pr	cince G	eorge's
Fune	ral	5. Social Security Num		Sex	7. Age (In yrs. <b>78</b>	last birthday)	If Under		If Under	24 Hrs.	8. Date of Bi	rth	9. Bin	hplace (State or Foreign
Direct		578-22-368	3	1 <b>X</b> M 2□ F	78	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D 4/19/	25	Uppe	rMarlboro, M
D		Usual Residence of De	ecedent											
ylan	4		0b. County		10c. Ci	ty, Town or Lo					-1-4			10d. Inside City Limits
Mar Fied	ģ	Md.		P.G.				rair	moun	t Hei	gnts			1 XYes 2 No
r 28	Director	10e. Street and Number	er				10f. Zip	Code				10g. Citiz	zen of What Co	untry?
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leath ne 2	Funeral	11. Marital Status		12. Was Dec	edent Ever in L	I.S. 13.	Was Deced	dent of Hi	ispanic Or	igin? (Spec	cify Yes or Na Rican, etc.)	o- 1	14. Race - Ame	rican Indian,
fer f	Ē	1 Never Married	2X Married	Armed Fo	orces? 2 □ No		If Yes, spec	cify Cuba	n, Mexica	n, Puerto F	Rican, etc.)		Black, Whit	
21215-0036  I within 72 hours after death with the Maryland jiene rithan 'natural', or Itema 23a or 28e-f show	6	3 ☐ Widowed 4 [	Divorced	If Yes, Gi Year or D	2   No ive   43 -   4	15	1 🗆 Yes	2 <b>X</b> No	Specify:	•			Specify: B	lack
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21215-0036 ad within 72 hours aff rgiene. or than "natural", or	pie	(Specify Elementary/Seconda		ade completed)	1-4or 5+)	16a. Dece (Give life.	kind of wo. DO NOT us	rk done d se retired	during mos !)	it of workin	g			
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Maryland of 2 should be file the and Mental Hy 27 is marked oth traumatic event	-	19a. Informant's Name	/Relationship	Type, Print)		19b. Mailir	ng Address	(Street a	and Numb	er or Rural	Route Numb	er. City or	Town, State, 2	(in Code)
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s 1 and 3 feeth item 27		20a. Method of Dispos	ıtion		20b. i	Place of Dispo	sition (Nan	ne of		Da			cation - City or	Town, State
		1 ⊠ Burial 2 □ C				cemetery, crer aryland				1/2	6/04		tenham,	
ting riteria		`4 □Donation 5 [			1,10	-					.0/04	CHEL	cernam,	TRA •
Baltimo permit. Page Department c Importent: If any injury or	once	21. Signature of Funer	MU V	( )	. 11	H	?. Name an I₋S₋Wá	a Addres	is of Facili naton	<sup>y</sup> & Sc	ns Co.	.Inc		D.C.20019
402	-				all								ington,	
		23a. Part1. Enter the c shock, or heart fa	disease, or con allure. List only	one cause on	caused the deat each line.		-		1	cardiac or	respiratory a	rrest,		Approximate Interval Between
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/Medic		resulting in death)	•	Due to	(or as a consec	quence of):	2							
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that set that the	<u>۷</u>		nt conditions	contributing to d	leath but not res	ulting in the u	nderlying c	ause give	n in Part I		23e. Did 1	obacco us	se contribute to	the cause of death?
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Division of Vital Records, lor Attending Physicien: The law requires tafer death.  Director: After this certificate has been signe in by the funeral director, page 2 should be a	u o	27. Manner of Death  1 XNatural	Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury		8c. Injury Work	?		Bd. Describe	how injury	occurred	
VISION Attending r death. ector: After	cat	2 ☐ Accident 3 ☐ Suicide	investigatio				М		/es 2□	No				
Divi	Certification:	4 ☐ Homicide	determined	286. Place	e of Injury - At h ing, etc. <i>(Specil</i>	ome, farm, str y)	eet, factory	, office		28	3f. Location ( City or To	Street and wn, State)	Number or Ru	ral Route Number,
ital c	ပီ					1711								1-5
Hospital Hospital 24 hours a Funerel i	edical	29a. Certifier 1) (Check only 2	Certifying Pl	nysician: To the miner: On the b	e best of my kno asis of examina	owledge, death	occurred a	at the tim	e, date an	d place, ar	nd due to the	cause(s) a	and manner as	stated.
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To the To the	Σ	29b. Signature and title	of certifier			m	290	. License			I .		signed (Month	
n.		1 6				7-16	ノ <u> </u>	D	58	18	2	4	-19-C	4
(2)	1/	30. Name and address	-			n 23a) (Type,	Print)	,			111		-19-0 D 201	0
الاس	VI	DR C. DONAL	D GECK	GE	3001	HOSPr	TAI	DRIN	E	Cx	KVERL	Y, M	1 201	85
	State	31. Date filed (Month, I	Day, Year)	32. F	Registrar's Signa	ature _								
Reg	istrar	APR 2	2 1 2004	Alex	a st	A STATE OF								

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Thomas Willard McCullough Apri1 17, 5:00P M 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Villa Rosa Nursing Home Mitchellville Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 187-01-5203 87 10.1917Pennsylvania Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location ral, or items 23s or 28s-f show Examiner roust be notified at 1 XYes 2 □ No Director Prince George's Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7616 Finns Lane 20706 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Market and page. Armed Forces:
1 Types 2 No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dairy Manager 4 Retail Food 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Hamilton McCullough ပ Stella Gilkey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20716 19a. Informant's Name/Relationship (Type, Print) Dorothy B. McCullough/spouse 3850 Enfield Chase Ct. Apt. 211 Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MD. Veterans Cem. 4-22-2004 Cheltenham, MD. 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. our 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Pheumonia 6 weeks /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ heart failure 2 No 3 Probably 4 □Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signaty and title of certifier 29c. License number 022780 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway (tr Dr Greenbelt MOZo776 MD Schissler 31 Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 0 2004 Registrar

ACREA INTRODUCTION  FOR COLUMN ACCURATE NITRO COLUMN ACCURATE NITR			_ FUI	artment of Health and Me		ne 2004 14611
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The state of the s	036 ours after de ral', or Itam	by Fune	1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married If Yes, Give	If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, White, etc.  Specify:
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Provided   Provided	land 2 lid be filed fental Hygi rkad other	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name		den Surname)
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Provided   Provided	Te, No. 1 and Health lam 27 Sthart		20a. Method of Disposition 20b. Place of Disp	osition (Name of Da		
Provided   Provided	Pages Bent of nt: If it	)	1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, cre		)/04 AT	EXANDRIA VIRGINIA
Projection   Mice of Cause (Final decases or condition resulting in death)   Sequentially list conditions, and consequence of):	Balti permit. Departm Importa any inju	Sile	21. Sign rure of funeral Service Licen as (	22. Name and Address of Facility EDWARD SAGEL FUNERA 1091 ROCKVILLE PIKE	L DIRECT	ION, INC. LLE, MD 20852
The state of the s	/Medica Examine	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  SEVERE MALNUTRIT  Due to (or as a consequence of):  Due to (or as a consequence of):			Onset and Death
SACRAL DECUBITUS ULCER; CONGESTIVE HEART FAILURE    1   Yes   2   No   3   Probably   4   Unknown	death death e atter	yslcian/Mec	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3  4 Pregnant at time of death 5			
25. Was case referred to medical sexaminer?  26. Place of Death (Check only one)  27. Warring Home 5 Residence 6 Other (Specify)  28. Date of Injury  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Check only one)  28. Date of Death (Month, Day, Year)  28. Date of Injury  28. Date of Death (Month, Day, Year)  28. Date of Injury  28. Date of Injury  28. Date of Death (North, Day, Year)  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  29. Date of Injury  29. Date of Injury  29. Date of Injury  29. Da	Se Se			, , ,		
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1 Natural 2 Accident 3 Suicide 4 Homicide 5 Homicide 6 Could not be determined 8 Homicide 9 Homicide 4 Homicide 4 Homicide 6 Homicide 8 Homicide 9 Homicid	Vita sician certifi	00	examiner?	Othor		e 6 □Other (Specify)
29a. Certifier (Check only one)  29b. Signature and title of person we completed cause of death (Item 23a) (Type, Print)  MARY CALLSEN, M.D., 6000 EXECUTIVE BLVD., #300 ROCKVILLE, MD 20852  31. Date filled (Month, Day, Year)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of person we completed cause of death (Item 23a) (Type, Print)  MARY CALLSEN, M.D., 6000 EXECUTIVE BLVD., #300 ROCKVILLE, MD 20852		1	27. Manner of Death  1 X Natural 5 Pending (Month, Day Year)  28b. Time (Month, Day Year)	of 28c. Injury at 28 Work?		
(Check only one)    Check only one)   Check one)   Check only one)   Check only one)   Check one)   Check only one)   Check one)   Check one)   Check one)   Check one)   Chec	in Piere		determined 286. Place of injury - At nome, farm, s	treet, factory, office	Bf. Location (Stree City or Town, S	t and Number or Rural Route Number. iate)
29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person to completed cause of death (Item 23a) (Type, Print)  MARY CALLSEN, M.D., 6000 EXECUTIVE BLVD., #300 ROCKVILLE, MD 20852  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Hos 4 h 5 ur	edical	(Check only 2 Medical Examiner: On the basis of examination and/or i	th occurred at the time, date and place, as nvestigation, in my opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
30. Name and address of person of completed cause of death (Item 23a) (Type, Print)  MARY CALLSEN, M.D., 6000 EXECUTIVE BLVD., #300 ROCKVILLE, MD 20852  31. Date filled (Month, Day, Year)  32. Registrar's Signature	To th Withi To th	Σ	29b. Signature and the of Jertifier		29d.	Date signed (Month, Day, Year)
MARY CALLSEN, M.D., 6000 EXECUTIVE BLVD., #300 ROCKVILLE, MD 20852  31. Date filed (Month, Day, Year) 32. Registrar's Signature	1				AP	RIL 19, 2004
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature					LE, MD	20852
Registrar APR 2 2 2004 Sement S Apaulit				Sparker		

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 21, Edward April Roland Nairn, Jr. 2004 9:30P. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Mariner Health of Silver Spring Montgomery Silver Spring If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCt. 12, 1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Washington, D.C. 1 XM 2 ☐ F 82 577-12-6605 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ral, or items 23a or 28a-f show Examitrer nated by notified at 1 ☐ Yes 2 ☑ No Silver Spring Maryland Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 United States 3116 Gracefield Road, #117 Funera 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 No If Yes, Give Year or Dates: WWII t ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "netural", or 1 ☐ Yes 2 No Specify: Specify White þ 3 ☐ Widowed 4 ☐ Divorced the Madical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) NSA 12 Security Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be fits Department of Health and Mental hy Importent: if item 27 is marked oth any injury or other treumaltic event once. Frances Juanita Sweeney Roland Edward Nairn, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type, Print) 3116 Gracefield Rd., #117 Silver Spring, Maryland Ann M. Nairn, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 5/5/2004 Arlington, Virginia \* 4 Donation 5 Other (Specify) Donald V. Forgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 21. Signature @ Funeral Service Licensee may 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS Physician PARKINSON'S DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No 5 Cher (specify) 4 Pregnant at time of deeth 9 Unknown requires that the s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an aw rias autopsy performed page this certificate 1 ☐ Yes 2√ No Division of Vital Attending Physicien: 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide ō 1 Xcertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D09834 April 22, 2004 Cosers 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry N. Rosenbaum, M.D. 3720 Farragut Avenue Kensington, Maryland 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 23 2004 Registrar

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	Physician	1. Decedent's Name (First, Middle, Last)	2. NOLAND			2. Dete of Death Month De	y Year	3. Time of Death  09/5 AM
	/Medical Examiner	4e Fecility Name (If not institution, give s	treet end number)		b. City, Town, or Loc SILVER S		. County of Deeth	
	Funeral	FOREST GLE  5. Social Security Number 6. Sex 212-02-6521 1□				8. Date of Birth (Month, Dey, Yeer) NOV • 25 , 19		olace (State or Foreign ryland
	Director	Usual Residence of Decedent	-33	TIS.	1   1	10v.25,19	969 Mai	ryland
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	or 28a-4 s be notified Director	10e. Street end Number		10f. Zip Code		10g. Cit	tizen of What Coun	ntry?
	23a r	8 Moore Dr			0850		USA	
980	ours after Mr. or its Examine by Full	11. Marital Status  1 Never Married 2 Married  3 Widowed 43 Divorced	2. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Detes:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Spec n, Mexican, Puerto R Specity:	ofty Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: B1	etc.
Maryland 21215-0036	ed within 72 ho ygiene. Nor then "naturi nt, tre Medical.	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cetion 10 completed) College (1-4or 5+)	6e. Decedent's Usual Occupe (Give kind of work done o life. DO NOT use retired, Cashiel	during most of working )	g	(ind of Business/Ind Restaur	-
nd 21	THE O	12th 17. Father's Neme (First, Middle, Last)	-	Casillei	18. Mother's Name	(First, Middle, Maiden	Sumame)	
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	end 2 st salth and 127 ia n er traur	19a. Informant's Name/Relationship (Type Carroll T. Lee,		•	Adams St	reet, Ro	ckville	, MD
Baltimore,	Peges 1 ent of He nt: If Item y or oth	20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	ceme	of Disposition (Name of hery, crematory or other place CO Funeral S			ocation - City or To Alexand	ria, VA
Balti	permit. Pe Depertmen Important: any Injury	21. Signature of Funeral Service License	Snowler	22. Name and Addres	ash. St.	, Rockvi		OME, P.A. 20850
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. De cause on each line.	o not enter the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a.	Glioblasto  Due to (or as  Hemi ple	ma Multi	forme	of brai	n	03/2003
	st st	_ b	Hemi ple	gia of le	ff side	,		03/2003
ó	be axecuted iclan and burial-transit	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury c.	Due to (or es	a consequence of):				
8760,	cate phys the	Cause (Disease or injury that initieted events resulting in death) Last	Due to (or es	e consequence of):				
Box 6	death certific e attanding p ed for usa as	d.						
	D 0 2 =	Pert II. Other significant conditions cont	ributing to deeth but not resulting	g in the underlying cause give	en in Part I.	23b. Did tobacco	use contribute to	the cause of death?
s, P.O	requires that the de een signed by the a hould be datached i	G Tube +	Feeding			1   Yes 2	.□ No 3 Prot	pably 4 □ Unknown
of Vital Records,	_ 00	G Tube f Trached				24a. Was an autoperformed?	ava	ere autopsy findings ailable prior to mpletion of cause death?
E R	The law rate hes paga 2	Cardio-	Respiratory.	failure		1 □ Y90 2	¥No 1□	]Yes 2□ No
Vita	entific ector Be	25. Was case referred to medical examiner?	ospitel:		26. Place of Death			
to o	High Paris	1 ☐ Yes 2 ☑ No  27. Menner of Deeth	1 □ Inpatient 2 □ ER/	Outpatient 3 DOA  Time of 28c. Injury Nork	at 28	e 5 Residence		)
ion	Attending F r death. ector: After by the funer ification:	1 Neturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)		t? Yes 2 □ No			
Division	To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: After t complataly filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28	of. Location (Street and City or Town, State	nd Number or Rura. i)	l Route Number,
	Ne Hospit ne Funeri plataly fill edical		cian: To the best of my knowled er: On the besis of examination and manner stated.					
	To the comp	29b. Signature and title of certifier		29c. License	number		te signed (Month, L	
		Chowdhy			3/21		4/14/20	
		30. Neme end eddress of person who odn NUR UL CHOWDH	npleted cause of death (Item 23d ルRY,Mカテジ	e) (Type, Print) 41 KING CHA	RLES WI	M'S BETH	ESDA, N	1020814
	State	31. Date filed (Month, Dey, Year)	32. Begistrer's Signeture	A Someto	/			

14614 Reg. No. 2. Date of Death 3. Time of Death Month Day **Physician** 5:45 P M April 7, 2004 /Medical 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□ F Months Days Hours Min. 75 Director 330**-**24-3787 20, 1928 Illinois Aug. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Montgomery Directo Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12007 Titian Way 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1XYes 2 No
If Yes, Give
Year or Dates: Korea 1 Never Married 2K Married 1 Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Executive Federal Government and Mental Hygin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 Is marked o Joseph F. Novotny 0 Catherine Bramhall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12007 Titian Way, Potomac, Maryland 20854 Lois J. Novotny/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State April 11, ¹ 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium Bethesda, Maryland 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 BUU west Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer of Lung with Metastasis **Physician** /Medical Due to (or as a consequence of): **Examiner** Respiratory Failure Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Idiopathic Pulmonary Fibrosis that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 □ No detached 9 Unknown 9 Linknown ģ been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2⊠ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier V- Nosuph D47330 XI worms April 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 West Edmonston Drive, Rockville, Maryland 20852 Thomas V. Joseph, M.D.

State

Registrar

31. Date filed (Month, Day, Year APR 14

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

2004

			Please I	ype or Print in Black	indelible ink. Er	nsure All	Copies	Are Legib	le.
			1 - State	State of Maryland / De	epartment of Heal Sertificate of Dea	th and Me			04 14615
			Registrar  1. Decedent's Name (First, Middle, Last)		rettificate of Dea		2. Date of Deat	g. No.	3. Time of Death
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2	/Medic Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Local		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4c. County of	
26	E ACTION		BROOKE GROVE N	IURSING HOME	SANDY SP	PRINGS		MONTGO	OMERY
	Funeral	11	Social Security Number     6. Sex	114 OFF	Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		224-49-99 Usual Residence of Decedent	92 Yrs	5.		(Month, Day, Nov. 22	,1911	Iran
	land		10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	Mary	ţor	Maryland Montg	omery Olne	У				1 ¥ Yes 2 □ No
	or 28s	irec	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	at Country?
	23a c	Funeral Director	17517 Lafayette	Dr.	20832			Iran	
	tems	nuel		Was Decedent Ever in U.S.     Armed Forces?	<ol> <li>Was Decedent of Hispanic If Yes, specify Cuban, Mer</li> </ol>	c Origin? (Spec xican, Puerto P	cify Yes or No- Rican, etc.)		American Indien, White, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	1 ☐ Yes 🎾 No Spe	ecity:		Specify:	Vhite
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Madical Examater must be notified at	ted t	15. Decedent's Educ	ation 16a De	ecedent's Usual Occupation		1	16b. Kind of Busi	ness/Industry
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lud	be fill d oth	Be	17. Father's Name (First, Middle, Last)	a d i				faiden Sumame)	
<u>\Z</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show aumatic event, the Madical Examiner cust be nuffiled at	<sup>L</sup>	Bagher Nadjmab			obba	Nadjm		
Maryland 2121	d 2 si th an t7 is r traur		Hamid Nadjmabad		ailing Address (Street and Nu 17 Lafayett			•	) 8 3 2
ē,	s 1 and 7 Health item 27 other tr		20a. Method of Disposition	20h Place of Di	concition (Alama of		-		ty or Town, State
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menia Important: If item 27 is marked any injury or other traumatic e once.		1 □XBurial 2 □ Cremation 3 □ Re  `4 □ Donation 5 □ Other (Specify)		crematory or other place) nd National	4-9-0	04 1	_aurel.	Maryland
alti	permit. Departm Importa any inju		21. Signature of Funeral Service Ligense	· 111 = 1	22. Name and Address of F	Facility Univ			
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			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death. Do not e cause on each line.				st,	Approximate Interval Between Onset and Death
	Physician	ei i	Immediate Cause (Final disease or condition resulting in death)	Acute	tubular	necr	osis		2 dcys
	/Medical Examiner		1	Due to (or as a consequence of):					
1	F1 77	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of).					
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60,	e be executed rsician and e burial-transit		resulting in death) Last	Due to (or as a consequence of):					
	ate but hysic the but	licat	d.						
x 68	leath certificate attending phys I for use as the	Physician/Medio	IF FEMALE:	sc. If yes, outcome of pregnancy					
Вох	ath officer	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	of delivery Day Year
o.	0 6 0	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	a district (apacity)				
a` ′o`	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions cont	1	e underlying cause given in P	art I.	23e. Did toba	acco use contribu	ite to the cause of death?
ğ	v require been sig should b		Atheroscle-	atic diseuse			1 🗆 Yes	2 20 NO 31	Probably 4 Unknown
ဝင္ပ	law re as be 2 sho	ompieted					24a. Was an autopsy	24b. We	re autopsy findings available r to completion of cause of
<u> </u>	The law cate has page 2:	Con					perform	ęd? dea	
Vital Records,	i <b>ician:</b> Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:	0.1		Check only one		
ō	Phys r this ral dir	2	1 Yes 2 XNo  27. Manner of Death	I □ Inpatient 2 □ EH/Outpa				ce 6 Other	(Specify)
O	th. th. tune fune	tion	1X□Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur			o. Describe nov	riquiy occurred	
Division of	Atter er dea ector by the	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm,	street, factory, office	28	f. Location (Stre	et and Number	or Rural Route Number,
ā	tel or	Cert	4 - Homeide	building, etc. (Specify)			City or Town,	State)	l.
	To the Hospitel or Attending Physician: which 24 hours stifer deals.  To the Funeral Director: After this certifical completely filled in by the funeral director;		(Check only 2 Medicer Examin	cian: To the best of my knowledge, deer: On the basis of examination and/or	eath occurred at the time, date rinvestigation, in my opinion.	e and place, an	d due to the cau	use(s) and manne	er as stated.
	the thin 2 the mplet	Medical	29b. Signature and title of certifier	and manner stated.	29c. License numb				Month, Day, Year)
)			> All Mass			55694	1	4	9,2004
	V		30. Name and address of person who con	npleted cause of death (Item 23a) (Tvi	- D-i-1)			11-71	11007
9				- Laytonsville	Rd Olsey	, MD	208	32	LOK MATHUR
	Sta	100	31. Date filed (Month, Day, Year) APR 13 200	40 0 11 101	draw.				
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			1- For State of Registrar	Maryland /		artment tificate			nd Mental F	lygien Reg. N	7 11 11	14	146	16
	Physici /Medic		1. Decedent's Name <i>(First, Middl</i> e, Last)  Ethel Caroline Niema	an					2. Date of Month April	D		ear	3. Time of De	
	Examir		4a. Fecility Name (If not institution, give street and num					Location of	Death		c. County of I	Death		
	Funeral Director		213-42-9780 1 N X	7. Age (In yrs. last b	birthday) Yrs.	If Under Months	eder 1 Year Days	If Under 24	Hrs. 8. Date of (Month, May3)	Birth <i>Day, Y</i> ea		ick Birthplac Country Iinne	se (State or Fi	oreign
	nyland how		Usuel Residence of Decedent  10a. State 10b. County	10c. City, To								10d	. Inside City L	
	the Ma 28a-f s	ecto	Maryland Frederick  10e. Street and Number	Th	urmo	nt 10f. Zip	Code		·	100.0	itîzen of Wha	t Country	Y∏Yes 2	□ No
	23a or	al Dir	113 Easy Street, Unit23			101. 210		788			ited S			
920	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. artiment of Health and Mental Hygiene. ordent: If item 27 is marked other than "natural", or items 23e or 28e-f show ordent: If item 27 is marked other than "natural", or items 23e or 28e-f show injury or other traumatic event, the Medical Exam incrinial be notified at e.	by Funeral Director	11. Marital Status 12. Was Decernated 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ☐ If Yes, Give Year or Da	2 XNo		Was Decedor f Yes, spec I ☐ Yes 2		panic Origir , Mexican, F Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - A Black, \ Specify:	American White, etc Whi		
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Maryland	12 should be filed within "h and Mental Hygiene." F is marked other than "Iraumatic event, the Med	To Be (	17. Father's Name (First, Middle, Last) Louis J. Schmidt						Name (First, Midde • Whiting		n Sumame)			
	1 and 2 sho Health and N am 27 is ma other trauma	ľ	19a. Informant's Name/Relationship (Type, Print) Roger L. Nieman —son	19 <b>1</b>	9b. Mailin 6366	g Address Mari	(Street ar	Circ	or Rural Route Nur le North	nber, City Pemb	or Town, Sta roke P	ines	, FL.3	3331
Baltimore,	Pages 1 and of He int: If item iry or oth		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from S  4 □ Donation 5 □ Other (Specify)		tөгу, c <del>гө</del> п	natory or ot	her place,		Date /19/2004		ocation - City			d
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	W-	DO	Name and	V. B	of Facility	rdt Funer Rd. Belt	al Ho	ome. P	Δ		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death)  a. Due to (continue)	used the death. Do ch line.	o not ente	er the mode	of dying,	such as ca	rdiac or respiratory	arrest,	re, Ma	Ar	pproximate terval Betweenset and Dea	en
8760,	cate be executed chysician and the burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease of Figure that initiated events c.	or as a consequence										
O. Box 6	The law requires that the death centificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 18 months?	ome of pregnancy th 2 Fetal deat nt at time of death wn		Ectopic pre					23d. Date of Month	f delivery Da	y Year	r
ط	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to dei	ith but not resulting	in the un	nderlying ca	use giver	in Part I.			use contribut		cause of death	0
Il Records,		Completed	cerebil car as	Lu cl	lin.	een				topsy rformed?	prior	to complet?	findings ava etion of cause	lable e of
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 In	patient 2□ER/0	Outnation	3 DO	Other	1000	Death Check onling Home 5 Re		6 COM (	Consifu)		
ion of	ding After fune	atlon; To	27. Manner of Death  12. Natural 5 Pending (Month)  2 Accident investigation	The second second second	Time of Injury		c. Injury a Work?	4 🗀 IAUISI	28d. Describ			Sр <del>ө</del> спу)		
Division	al or Attences after death I Diractor: Id in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of buildin	of Injury - At home, f g, etc. <i>(Specify)</i>	farm, stre	eet, factory,	office		28f. Location City or 1	(Street a. own, Stat	nd Number o. e)	r Rural Ro	oute Number,	
	To the Hospital or Attend within 24 hours after deatl To the Funeral Diractor; completely filled in by the	Medical (	29a. Certifier (Check only one) 1 Aedical Examiner: On the base and manner	sis of examination a	ge, death and/or inv	occurred a estigation,	t the time in my opir	, date and p non, death	place, and due to the occurred at the time	e cause(s e, date an	and manne d place, and	r as state due to the	d. e cause(s)	
	Vilhii To th	M	29b. Signature and title of certifler	11 -		29c.	License	number		29d. Da	ate signed (M	lonth, Day	r, Year)	
	5		30. Name and address of person who completed cause	of death (Item 23a)	) (Type, F	Print) /	1)	7 71(	-	The	ul 1c	1. K	NY	
0			31. Date filed (Month, Dat, Year) 32. Re	ofistrar's Signature	147	St	ing	a	1. Fre	Leu	Lu	021	1762	
1	Sta Registr		APR 1 6 2004	per la la cignatura	9	Spa	Ks	ν	·					

		1 For State	State of Maryland /	Department of Health and M	lental Hygie	ne2001 11.617
		Registrar  1. Decedent's Name (First, Middle, Li	ast)	Certificate of Death	Reg.	
Physic		alles	Nichale		Month	Day Year
/Medi		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or Location of Death	17001 E	4c. County of Death
Lxaiiii	iei	3769 Payne	Road	Preston		0
Funeral		5. Social Security Number 6.	Sex, 7. Age (In yrs. last t	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Director		14-11-100	14M 20F 8	Yrs. Months Days Hours Min.	Oct 27	1922 Delaware
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City. To	wn or Location		10d. Inside City Limits
Maryi 4 sho	ĕ	Maryland Carol	ine Pres			1 ☐ Yes 2 No
ith the Marylar or 28a-f show	rec	10e. Street and Number	0 1	10f. Zip Code	10a.	Citizen of What Country?
death with the Maryland ms 23a or 28a-f show Entast be natified at	Funeral Director	3769 Payne	lLoad	21655	Un	ited States of America
ems ems	Iner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
36 s afte	by Fu	1 ☐ Never Married 2 ☐ Married	1 Yes 2 □ No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: D
1215-0036 within 72 hours after and "naturel", or Ite	ed b	3 Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:	a. Decedent's Usual Occupation	401	DIACK
15 in 72 in 72 in 19	Completed	(Specify only highest gr	ade completed)	(Give kind of work done during most of worki life. DO NOT use retired)	ng	. Kind of Business/Industry
d with giene	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Mechanic	P	rinting Industry
nd al Hy se file sother	Be	17. Father's Name (First, Middle, Las.	2		(First, Middle, Maid	den Surname)
ylan ould be Mental Marked c	၉	Frank Pri	tcheff	Lucy 0	U.Ison	Nichols
<b>₽</b> % ₽ ₽ ₽		19a. Informant's Name/Relationship	(2)	b. Mailing Address (Street and Number or Rura	l Route Number, Cit	ty or Town, State, Zip Code)
Fe, Tanger 1 and Health		Mark Lawbur  20a. Method of Disposition		2 Dowling Circle of Disposition (Name of	Parksi	
nor of or of or o		1 Burial 2 □ Cremation 3	Removal from State	ery, crematory or other place)	26 7004	Location - City or Town, State
Baltimore, Me permit. Pages 1 and 2: Department of Health at Important: If item 27 is any Injury or other treaunce.		* 4 □ Donation 5 □ Other (Speci 21. Signature of Fune al Servi e Life		22. Name and Address of Facility 1.10	200	1000 1001 1110
Balt permit. Departr Import		) Ret	Tr	510 1136 his La	The Pont	ered theres
		23a. Part1. Enter the disease, or com	plications that caused the death. Do	not enter the mode of dying, such as cardiac o		Approximate Approximate
Physician	S 17	Immediate Cause (Final disease or condition	A company	MYELOGENOUS	1 LUNG	Interval Between Onset and Death
/Medical		resulting in death)	a.  Due to (or s a consequence	V	5 Lique	MILL FIONINS
Examiner	_	Sequentially list conditions,	b			
pe sit	line	cause (Disease or injury	Due to for as a consequence	uf).		
xecut and II-tran	Examiner	that initiated events resulting in death) Last	c	) of):	<del></del>	
18760, cate be executer physician and the burial-trans	dicai E					
687 tificate tg phys as the	edic		. 0.			
Box 6 eath certific attending p	NZ.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	h 3 Ectopic pregnancy	)	23d. Date of delivery
O. B he death the atter hed for	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death	5 ☐ Other (specify)		Month Day Year
P.O.	Phy	9 Unknown			1	
Se est	۵	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 □ Probably 4 □ Unknown
Cord w requir been si	etec					/\
I Re( The lavate has	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Ficien: The certificate	0	25. Was case referred to medical		OC Place of Parth	1 Yes 250	No 1 ☐ Yes 2 ☐ No
of Vita Physician: this certific	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 ER/O	26. Place of Death utpatient 3 □ DOA Other: 4 □ Nursing Hom		6 ☐Other (Specify)
on of	Ë	27. Manner of Dath 1 Natural 5 □ Pending	28a. Date of Injury 28b.		8d. Describe how in	
Vision Attending r death. ector: After	catic	2 ☐ Accident investigation		M 1 ☐ Yes 2 ☐ No		
or Att fter d frect in by	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specily)	arm, street, factory, office 2.	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
pital purs a burs a eral (	2	29a. Certifier (X) Certifying Ph	valeign. To the best of multipouted			
Hos 24 ho Fun stely	edical	(Check only 2 Medical Exam	niner: On the basis of examination ar and manner stated.	e, death occurred at the time, date and place, and/or investigation, in my opinion, death occurre	nd due to the cause( d at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
			-111	29c. License number	29d. D	ate signed (Month, Day, Year)
To the		29b. Signature and title of certifier	7 / // //			- 1
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		29b. Signature and title of certifier	hh	DO053094	_	4-71-2004
To the within To the compile	2	Ilala Jan	completed cause of death (Item 23a)	(Type, Print)		4-21-2004
C.H.3+	Σ	30 Name and address person who	completed cause of death (Item 23a)	(Type, Print) (S2) Bloom sudale	Ave Fed	4-21-2004 enulburs MD 21632
Sta Registr	≥	30. Name and address person who	1BOVD M D 3	(Type, Print) Bloominydale	Ave Fed	4-21-2004 Mulbury MD 21632

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14618 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 26 Month 04 04 **Physician** NUSE 4:00 Am Η. JAMES /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner WORCESTER BERLIN 29 MYSTIC HARBOR BLVD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-8-1932 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Davs PENNSYLVANIA 1√2 M 2□ F 72 Yrs 179-24-0709 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND WORCESTER BERLIN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US 29 MYSTIC HARBOR BLVD 21811 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 1952— If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: þ 3 X Widowed 4 □ Divorced Year or Dates: 1954 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if them 27 is marked other than "ne any injury or other traumatic event STEEL College (1-4or 5+) Elementary/Secondary (0-12) MANUFACTURER 12 STEEL MILL WORKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERT NUSE RUTH BAXTER ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29 MYSTIC HARBOR BLVD., BERLIN, MD. 21811 MILDRED HUMPHREYS 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition CONESTOGA MEMORIAL PARK 4-30-04 1 XBurial 2 □ Cremation 3 □ Removal from State LANCASTER, PENNSYLVANIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fun val Solvice 22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD. THATCHER ST, FRANKFORD, DELAWARE. 19945 Part . Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CCCCWonz hogen Examiner Due to (or as e consequence of): Physician/Medical Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): signed by the a 23b. Did tobecco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 □ No þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? page 2 should Completed completion of cause of deeth? has 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2<u>₽1</u>No 1 Yes Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

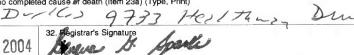
2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical To the I within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

2.H.6 State Registrar

31. Date filed (Month, Day, Year) APR 2 8 2004

Robert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



my 516-8

DHMH 16 Rev 6/95

		1	1 - For State Registrar	State of Maryla	nd / Depa	artment of F	lealth and i Death	Mental Hy	rgiene2 0 (	) L <sub>4</sub>	14619
	Physici	an	1. Decedent's Name (First, Middle, La Loretta R. N	ewcomb				2. Date of De Month	Day	Year	3. Time of Death
	/Media		4a. Facility Name (If not institution, give	on atmost and symbols		4h City Town o	Location of Deat	April	24, 2004 4c. County o		0:30A M
	Examin	er	8600 Mike Shapir			Clint		11	Prince		0015
					s. last birthday)	If Under 1 Year		8. Date of Bi	rth		
	Funeral Director			1□M 2√√ 88	Yrs.	Months Days	Hours Min.	Aug. 16			e (State or Foreign
			Usual Residence of Decedent						1	irgin	1a
	ylan		10a. State 10b. County		City, Town or Lo						. Inside City Limits
	a-fs	ct O	Maryland Prince G	eorge's	Clin	ton					1 ☐ Yes 2ÑXNo
	ift th	Oire	10e. Street and Number			10f. Zip Code	_		10g. Citizen of Wi	nat Country	?
	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show he Medical Exami at must be rollited at	by Funeral Director	8600 Mike Shapir			2073			U.S.A.		
	tams er m	nne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)		<ul> <li>American</li> <li>White, etc.</li> </ul>	
36	s afte	Ę.	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give Year or Dates:		1□Yes 2□No	Specify:		Specify:	White	0
Ö	tural	b d	15. Decedent's E		16a Daca	dent's Usual Occup	ation		16b. Kind of Bus		
<u>.</u>	in 72 in na lection	Completed	(Specify only highest gr	ade completed)	(Give	kind of work done of DO NOT use retired	during most of wor	rking	100. 1010 01 000	110000111000	,
7	with iene.	шо	Elementary/Secondary (0-12) 9th	College (1-4or 5+)		School Bu	s Aid		P.G. Cou	nty S	chools
ਰੂ	othe	BeC	17. Father's Name (First, Middle, Last						, Maiden Sumame		
lar	uld be Aenta rrked rice	ToB	John	Frazier			Bessi	е	Seal		
Maryland 21215-0036	nd 2 sho alth and I 27 is mu ir traums		19a. Informant's Name/Relationship (Glenn R. Sommers	(Type, Print) (Grandson)	19b. Maili 1520.				er, City or Town, S ille, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itams 23s or 28e-f show any fiutry or other traumatic event, the Medical Experiment must be notified at once.	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Tuellioval itolii State	Place of Dispo cemetery, cree Lee Crei	sition (Name of natory or other place	1111	il 26,	20c. Location - C		
Ħ	artme ortan Injury	ŀή	<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>			2. Name and Addre			Clinton,		land
ä	Dep Imp		Keli R. Patt	w MØ1/90	4:		це	e funera ia Ferr	al Home, v Rd Clin	inc.	MD 20735
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the de							pproximate terval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Du-to (or as a const	Last 5	In France	t			Ör	nset and Death
	Examiner		Sequentially list conditions,	Mypeter	5710					ļ	183
	ted nslt	nine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	ful to for its a conse	1	5				- 1	1
<u> </u>	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):					2	!7'
8760,	icate be executed physician and s the burial-transit	dicai		d							
9	rtifica ng ph as th	Jed	IF FEMALE:								
Вох	leath certific attending p	an/I	23b. Was decedent pregnant in the past 12 quonths?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date Mont	of delivery h Da	v Year
o.	the all	Physician/Me	1 Yes 2 No	4☐Pregnant at tîme of 9☐ Unknown	death 5	Other (specify)			10000	, Du	, , ,
α_	that the de ned by the a detached f	Ph	Part II. Other significant conditions	contributing to death but not re	esultina in the u	nderlying cause give	en in Part I.	23e, Did 1	obacco use contrib	oute to the c	ause of death?
rds,	w requires that been signed I should be det	d by	Chrose Ward	Bisian				1 🗆	Yes 2□No 3	B ☐ Probably	y 4 🗓 Unknown
00	s bee	Completed	GI Blueding &	Htmor.				24a. Was		are autopsy	findings available
Re	The lay	mo	020/100	N pp				auto perfo	ormed? de	ath?	etion of cause of
ta	an: tiffica tor, p	0	25. Was case referred to medical				26. Place of Dea	ath (Check only	_A	X	2.140
>	yaici is cer direc	O B	examiner? 1 ☐ Yes 2√YNo	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	lome 5 X Resi	dence 6 Other	(Specify)	
0	ng Ph ter th neral	n: T	27. Manner of Death 1    Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		/ at		how injury occurred		
<u>0</u>	ttandir death. ctor: Al / the fu	atic	2 Accident investigation			M 1 🗆	Yes 2 □ No				
Division of Vital Records,	al or Att safter de l Diract d in by t	Certification:	3 Suicide 6 Could not be determined		home, farm, str cify)	eet, factory, office		28f. Location ( City or To	Street and Number wn, State)	or Rural Ro	oute Number,
	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my ki miner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the cred at the time,	cause(s) and mann date and place, an	ner as stated d due to the	d. 9 cause(s)
	To the Within To the	Me	29b. Signature and title of certifier			29c. Licens	a number		29d. Date signed (	Month, Day	r, Year)
)			Thumas Il	Tre late 81	D	Da.	1923			4-21	-2004
			30. Name and address of person who	completed cause of death (It	ет 23а) (Туре,		145				aw 7
1	B7		Thomas Fieldso	n, M.D. 2068 (	Crain Hy	vy, Waldo	rf, Mary	land 20	601		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	2. 8 2nn	Hereus	J. J.	Joseph			
	Registr	ar	4-26-200	4 PAIN		· Part	6				

			riedse i	State of Mar	vland / Den	artment of H	ealth and Me	ental Hygier	ne o o o	
		1	For State	State of Mai	yland / Dep Ce	ertificate of E	Death	Reg.	200	14 14621
æ.	A		1. Decedent's Name (First, Middle, Last)	)				2. Date of Death		3. Time of Death
	nysicia		catherine F		Nichols	*			Day Yea 1,2004	10:40 P.M
	Medic xamin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or		-	4c. County of D	
			Prince George's H	ospital Ce	nter	Chever				George's
	neral ector		5. Social Security Number 6. Security 578–62–8712	7. Age (	'In yrs. last birthday	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 5/13/39	ar) g. l	Birthplece (State or Foreign Country)  everly, Md.
pur		-	Usuel Residence of Decedent  10a. State 10b. County	1	IOc. City, Town or I	ocation.				10d. Inside City Limits
Manyli	D D	. 1		G.		Lan	dover			1 XYes 2 No
death with the Maryland		Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What	Country?
h with	2	at D	7436 Village Gree	n Terrace			20785		U.S.A.	
deat	E E	Iner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13	. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- lican, etc.)		merican Indian, /hite, etc.
within 72 hours after ene.	ritan hatura, or tema 53e or 50e-1 erow the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	Black
hours at			15. Decedent's Edu		16a. Dec	edent's Usual Occupa	ation	16b	. Kind of Busine	ess/Industry
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d with		Completed	10th	College (1-401 3+)		stodian				Complex
and A	event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	_	den Surname)	
	9 0	2	Arthur Nichols				Gladys D			77-0-4-1
2 shour and M			19a. Informant's Name/Relationship (T)  Judith Ann Morton,			ling Address (Street a 6 Village			-	
and 1 and Health	if item 27 or other ti		20a. Method of Disposition	DISCEL		position (Name of ematory or other place			. Location - City	
Pages nent of	700	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)			ematory or other place vet Cem.	<sup>θ)</sup> 4/17/	04 1	Jach i nat	con,D.C.
Department of	injur.	1	21. Signature of Funeral Service Licens							
	any ir		Jany W	· JAH		22. Name and Addres H.S. Washir 4925 Burro	ngton & So oughs Ave.	,N.E.,Was	h.,D.C.	20019
*			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	ne death. Do not e	nter the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
Phys	ician		Immediate Cause (Final disease or condition	Intrace		hemoerho	age			Onset and Death
/Me	dical		resulting in death)	_	consequence of):					0
Exar	niner		Sequentially list conditions,	. Hupert						
<b>9</b>	isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due a for as a	consequence of):					
<b>6U,</b> be executed	and al-tran	xan	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
/6U, ₽ ₩ .	ysician and ie burial-transit	calE		d.						
. BOX 68/	attending physical for use as the t									
BOX auth cert	endin r use	Physician/Medi	23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		☐Ectopic pregnancy			23d. Date of Month	delivery Day Year
. 0	he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4⊟Pregnant at til		Other (specify)			MORITI	Day rear
Hecords, P.O. The law requires that the	d by the a	Phy	9 ☐ Unknown  Part II. Other significant conditions co	entributing to death but	not resulting in the	underhing cause give	en in Part I	23a. Did tobac	co use contribut	e to the cause of death?
ies it	signed to be det	by		litus	not resulting at the	and snying datase give	on as a way	1 □ Yes		Probably 4 Unknown
VITAI RECORDS, sicien: The law requires t	should	Completed by	& Contraction of the Contraction					24a. Was an	24h Were	autopsy findings available
5 ĕ	has 3e 2	m I						autopsy performed	? prior	to completion of cause of h?
	certificate rector, pag		25. Was case referred to medical				26. Place of Death	(Check only one)	No 1	Yes 2□ No
	this certifical director.	To Be	avaminar?	Hospital: 1 Inpatient	t 2 ER/Outpati	ent 3 DOA Othe	on	ne 5 Residence	e 6 Other (S	Specify)
DIVISION OF VITA  I or Attending Physician: after death.	After thi		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day	28b. Time		y at 2 k?	8d. Describe how	njury occurred	
SIOF andin	or: Aft he fur	Certification;	2 ☐ Accident investigation				Yes 2□No			
DIVIS 1 or Att	Director: in by the	riffe	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, factory, office	2	8f. Location (Stree City or Town, S		r Rural Route Number,
lospital of	lled ii		CO. Cartilla Continue Bh	unising. To the best of	i mu kaawladaa da	oth accurred at the tra	no, data and place, a	nd due to the caus	o(c) and manne	r ac stated
± 2	To the Funeral Director: completely filled in by the	edical		ysician: To the best of niner: On the basis of and manner state	examination and/or					
To the within	To the complet	Mec	29b. Signature and title of certifier	111	1	29c. License	e number	29d.	Date signed (M	lonth, Day, Year)
F 3	- 0		D WILLIAM	TAMO	X,	15	8322	4	1/14/2	004
			30. Name and address of person who o	completed cause of de	ath (Item 23a) (Typ	e, Print)		2.0	0:- 00:-	
			SHIKHA KHOSLA			DRIVE, C	HEVERLY	, MD 2	0785	• 1
	Sta	ate	31. Date filed (Month, Day, Year)	82. Registrar	rs Signature				, i)	

Dh	io- <sup>†</sup>	1. Decedent's Name (First, Middle, La	MI	*	2. Date of Dea Month	th Day Yeer 3. Time of Do	
Physic /Med		ALLEN A. NICHOLO			APRIL	10, 2004 7:15	P M
Exam	ner	4a. Fecility Name (If not institution, giv		4b. City, Town, or Local		4c. County of Death	
5		PRINCE GEORGES I  5. Social Security Number 6. S	iex 7. Age (In vrs. last		nder 24 Hrs. 8. Date of Birth	PRINCE GEORGES  9. Birthplace (State or F	Foreign
Funera Directo		225 74 4655	XXM 2□F 49	Yrs. Months Days Hou	urs Min. (Month, Day DEC • 26		LINA
ը ,		Usuel Residence of Decedent  10a, State 10b, County	100 City T	own or Location		10d. Inside City	Limits
ahov	5					XXYes 2	
with the Maryland a or 28a-f ahow Le notified at	Directo	MARYLAND PRINCE ( 10e. Street and Number	SEORGES BLAD	ENSBURG 10f. Zip Code	1	log. Citizen of What Country?	
death with the Maryland ms 23a or 28a-f ahow rmust be notified at		4243 58TH AVENUE	#4	2071	.0	UNITED STATES	
death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
be filed within 72 hours after death w tal Hygiene. d other than "natural", or Items 23a event, the Machal Examinar must I	þ	XXNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes <b>XX</b> No If Yes, Give Year or Dates:	1 ☐ Yes XX No Spe		Specify: BLACK	
n 72 ho n matur	Completed	15. Decedent's E (Specify only highest gr.	ade completed)	6a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind of Business/Industry	
with jiene. r than	mo	Elementary/Secondary (0-12) 8TH	College (1-4or 5+)	CONSTRUCTION	I	PRIVATE	
e filed Il Hygid other	BeC	17. Father's Name (First, Middle, Last	)	18. N	Nother's Name (First, Middle,	Maiden Sumame)	
	10	WILLIE NICHOLSON			IELMA WESTRY		
2 g a a		19a. Informant's Name/Relationship (		19b. Mailing Address (Street and N.			
1 an Heal em 2	1	DELORIS STREATER  20a, Method of Disposition	20b. Piac	6402 JUANITA CT. e of Disposition (Name of		MD 20/46 20c. Location - City or Town, State	
0 0		1 Burial XXCremation 3 C	Hemoval from State	etery, crematory`or other place) OPOLITAN CREMATO	DRY 14-APR-04	ALEXANDRIA, VA	
	i :	21. Signature of Funeral Service Line		per transfer of the second		MARYLAND, INC.	
Departitum Departitum		I No All	Nary Lt	4308 SUITLAND	ROAD SUIT	LAND, MD 20746	
N.S.		23a. Part 1. Enter the disease, or com shock, o vieant failure. List only	polications that caused the death.	Do not enter the mode of dying, suc	ch as cardiac or respiratory are	III(B) VAI DOLWO	
Physician		Immediate Cause (Final disease or condition	SEPSIS			Onset and De	aun
/Medica Examine	-	resulting in death)	Due to (or as a consequer	nce of):			
9.0		Sequentially list conditions,	b. HIV  Due to (or as a consequer	nce of):			
uted 1 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause to iscasse or injury that initiated events	RENAL FAILURE				
te be executed ysician and e burial-transit	Exa	resulting in death) Last	Due to (or as a consequer				
ate be nysicia he bu	cal		d				
eath certificate be executed attending physician and for use as the burial-transit	Med	IF FEMALE:	220 If was automa of erograng			201 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance 1 Live birth 2 Fetal de 4 Pregnant at time of deat	eath 3 Ectopic pregnancy		23d. Date of delivery  Month Day Ye	эаг
that the de ed by the detached	yslo	1 Yes 2 No 9 Unknown	9□ Unknown	o El osnov (oposity)			
The law requires that the death certifica ate has been signed by the attending phrpage 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions	contributing to death but not resulti	ng in the underlying cause given in I	Part I. 23e. Did to	bacco use contribute to the cause of de-	ath?
w requires been sig should by					1 D Y	es 2XXNo 3 ☐ Probably 4 ☐ Un	iknown
law requas been 2 should	Completed				24a. Was autop	sy prior to completion of cau	
	Som				perfor	med? death? XX No 1 ☐ Yes 2 ☐ No	
ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospitalizzes	Othor	Place of Death (Check only or		
Physician: r this certific ral director,	2	1 Yes XX No			Nursing Home 5 ☐ Resid	ence 6 Other (Specify) ow injury occurred	
for Attending Physician: after death. Director: After this certific in by the funeral director.	tion	XXNatural 5 Pending	(Month, Day Year)	8b. Time of linjury at Work?  M 1 Yes		ow injury document	
Attending r death.  ctor: After by the fune	ifica	3 Suicide 6 Could not	28e. Place of Injury - At hom	e, farm, street, factory, office	28f. Location (S City or Tow	itreet and Number or Rural Route Number	er,
F 0 E 2	Certification:	4 Homicide	building, etc. (Specify)		City of You		
s after or all Dir	ledical (	29a. Certifier 1 XX ertifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of my knowle iminer: On the basis of examination and manner stated.			cause(s) and manner as stated.  date and place, and due to the cause(s)	
24 hours Funeral	- 0		1110	29c. License nun	nber	29d. Date signed (Month, Day, Year)	
24 hours Funeral	Med	29b. Signature and title of certifier	/ / / / / /		)		
Hospitel 24 hours Funeral tely filled	Med	29b. Signature and title of certifier	Slen	D538	350	APRIL 15, 2004	
24 hours Funeral	Mec	29b. Signature and title of certifier  30. Name and address of person who	o completed cause of death (Item 2	3a) (Type, Print)	SPITAL DRIVE	APRIL 15, 2004 CHEVERLY, MD	

State of Maryland / Department of Health and Mental Hygiene 200Anne C. Ohnstad 04-2507 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year Campbell Ohnstad 2004 Anne April 12. 4:03 P /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 16000 Small Grove Road Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.

Vonths Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Director 565-88-4866 64 Sept. 12, 1939 Nova Scotia, Canada Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or itema 23a 16000 Small Grove Road Funeral 20878 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than any injury og other traumatic event, the We apprings. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Campbell Oxley Edith Marie Zwicker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9519 Hickory Hill Drive, Andrew C. Ohnstad/ Son Fredericksburg, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State April 13, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2004 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part . Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Head Injuries /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispace of Injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medica The law requires that the death certificate the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 X Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No Jas page 5 certificate Division of Vital 1 Yes 2 □ No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certifica completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1X Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury 1 Natural 1 ☐ Yes 2 📉 No 2 Accident Found 4-12-04 Found 3:55 investigation Subject 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) | Laco Small Greek 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 16000 small Grove Rd home At wowe Gaithers burg m D

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) hi m. 0 O.C.M.E. April 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LI LING Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
APR 1 4 32. Registrar's Signature 2004

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** April 2004 Young Orenstein 5:20 A /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 024-16-7565 80 11, New York Director 1923 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location il Hygiene. other than "natural", or liems 23a or 28e-f show vent, It's Madical Examinar must be nutified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6121 Montrose Road 20852 United States Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: 3 √ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Importent: If Item 27 is marked other tt any injury or other traumatic event, Int once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Zimmerman Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MDBob Young, 7508 Old Chester Road, Bethesda, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) 4/15/2004 Beth El Cemetery W. Springfield, Mass. 21. Signatur of Fineral Se vice Licen; ee 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, MD are 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZH **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (c. as a consequence of). Examine Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 0 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 2,200 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No Vital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 dursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ۵ of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☐ Natural 2 ☐ Accident 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide in 24 hours. the Funeral Dire 1\(\text{ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2\(\text{ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier ithin 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **APR 14** 

Registrar

		,	T = For State Registrar	State of Maryland	d / Depa	artment of He	ealth and I	Mental Hy	•	4 14621
/	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last, Emm C Jean 4e. Fecility Name (If not institution, give The Johns Hopk 5. Social Security Number 6. Sec	street and number)  105 Hospital  7. Age (In yrs. la	ast birthday)		or Cis	2. Date of Dea Month April	Day Yea	4 2: Y/AM  Birthplace (State or Foreign
9	Director		Usual Residence of Decedent	M 2XF 61	Yrs.	Months Days	Hours Min.			ryland
	the Maryland r 28a-f ehow	Irector	10a. State 10b. County  Maryland Charl  10e. Street and Number		, Town or Lo	ughesvill	e		10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 No Country?
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Medical Examinat must be muitined at or other traumatic event, the Medical Examinat must be muitined at	by Funeral Director	15162 Hughesville  11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	Manor Drive  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 XNo If Yes, Give Year or Dates:	į.	20 Was Decedent of His f Yes, specify Cuban		pecify Yes or No o Rican, etc.)	US 14. Race - A Black, W Specify:	merican Indian,
21215-0036	rithin 72 hou ne. han "natura e Medical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) Homemake	iring most of wor	king	16b. Kind of Busine	,
C	ould be filed withing Mental Hygiene.  arked other than atic event, Ins. Mental Hygiene.	To Be Co	12 17. Father's Name (First, Middle, Last) William Albert Nel	son			18. Mother's Nan	ne (First, Middle,	Own Ho Maiden Sumame) av Hall	ome
ž	1 and 2 should Health and Men em 27 is marke	-	19a. Informant's Name/Relationship (7)  James Aubrey Owen				nd Number or Ru	ral Route Numbe	or, City or Town, State	e, <i>Zip Cod</i> e) 111e, MD 20637
Baltimore,	Fr Fr		20a. Method of Disposition	Removal from State Char	rnetery, crer cles Mer	sition (Name of natory or other place norial Garde	ns 4/7/			or Town, Stete
Bal	Departic Departic Imports any inji		21. Signature of Funeral Service/Linens  10. Charles 10.00  23a. Pert1. Enter the disease or complete	a Hade	P.0	Name and Address Littingley Gal  Box 270 L	eonardtow	n, MD 2065	0	Approximate
1760,	eath certificate be executed attending physician and attending physician and for use as the burial-transit	lical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):  OCA ente of):	ssist (	evice	Mali	function	Approximate Interval Between Onset and Death
.O. Box 68	00	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 24 740 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of decent of the pregnant at time of decent of the pregnant at time	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
rds, P	The law requires that the tee has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions co	ntributing to death but not resul	lting in the u	nderlying cause giver	n in Part I.			o to the cause of death?  Probably 4 Nthknown
		Completed						24a. Was autop perfor	sy prior t med? death	autopsy findings available to completion of cause of ?
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	fospital:		Other	-	th (Check only o		
Division of	Attending Physician: r death. sctor; After this certific by the funeral director,	itlon: To	27. Manner of Death  Natural 5 Pending 2 Accident investigation	patient 2 E	ER/Outpatier 28b. Time of Injury	28c. Injury : Work?	4   Nursing h		ence 6 Other (S	pecify)
Divis	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (S City or Ton		Rural Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, deatl ion and/or in	n occurred at the time vestigation, in my opi	, date and place nion, death occu	, and due to the or rred at the time, or	cause(s) and manner date and place, and o	as stated. lue to the cause(s)
)	To t com	Σ	29b. Signature and title of confifer	[ wo		29c. License			April 4	onth, Day, Year)
6	100		30. Name and address of person who co	completed cause of death (Item			fe st	Baltin	ore MD	71287
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		Scott B			10 10	2.00/

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#1,23a State of Maryland / Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Maryland / Department of Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Maryland / Department of Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Maryland / Department of Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Maryland / Department of Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Maryland / Department of Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Maryland / Department of Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Maryland / Department of Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Maryland / Department of Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Maryland / Department of Department of Health and Mental Hygiene 1- For per Phy.4/21/04 State of Department of 14625 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Doris Helen Potter Month Year **Physician** 2150C 1109 AM Helen APRIL /Medical 2004 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hospital Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 📆 F 86 Yrs Director 074-09-0040 11/29/1917 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Director Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 Severn Way 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 WNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 →Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Boddy Maybelle Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Frederick Potter 133 Severn Way, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 iment of E tant: if it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Metropolitan Crematory4/17/04 Alexandria, VA 21. Signature of Funeral Sepyiou 22. Name and Address of Facility Advent Funeral Services the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line. Annapolis, MD 23a. Parti. Energine dis shock, or heart fail. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Physician KINAL /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 type a 13 Duco D 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 6 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an HEART PALLURE CONGENTAL autopsy performed? Yes 22 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Latural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar 31. Date filed (Month, Day, Year)

SOLOMONS ISLAND RD ANN ND 21401 139 MPUTU istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Box 68760 certificate be

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Division Hospital or Attending

Physician:

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		_	State of Maryland / Department of Health and N  1- State Registrar Certificate of Death	•	<sup>2</sup> 004 14626
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year 3. Time of Death
	/Medic Examir	al	Hilton Powell  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	112/11	4c. County of Death
			May land General Hospital Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) It Under 1 Year It Under 24 Hrs.	8. Date of Birth	N/A  9. Birthplace (State or Foreign
	Funeral Director		216-18-5990 1⊠ M 2□ F 83 Yrs. Months Days Hours Min.  Usual Residence of Decedent	(Month, Day, Y April 20	ear) Country)
	with the Maryland a or 28a-f show Le retified at	5	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h the M r 28a-f r notifi	Director	Maryland Anne Arundel Annapolis  10e. Street and Number 10f. Zip Code	10g	. Citizen of What Country?
	ath wit	raiD	224 Croll Drive 21401		UŞA
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 ia marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, Its Medical Evaninar must be notified at once.	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married  2★ Married  1 □ Yes 2 □ No If Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
215-003	in 72 hou n "natura Nedical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16	b. Kind of Business/Industry
12	ed within ygiene. her than " t, Ine Mex	Com	6th 0 Heavy Equipment Ope		Reese King Co.
HON	d be fil ental H red oth c aven	Be	17. Father's Name (First, Middle, Last)  18. Mother's Nam  John W. Powell  Helen	e (First, Middle, Ma.	den Sumame)
aryl	should and Men a marke	၉	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run		ity or Town, State, Zip Code)
-	and 2 ealth a m 27 le		Theresa Powell(Wife) 224 Croll Drive An		Md. 21401
-Tou	Pages 1 nent of H int; If ita iry or ot		1 A Burial 2 Cremation 3 Removal from State Chews UM Church		c. Location - City or Town, State
Baltimore	permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee Cemetery 22. Name and Address of Facility	61-	wensville, Md.
	205 a d		Zavy A. Reese Moo 483 Wm. Reese & Son 821 West St. An 23a. Part. Enter the disease, or complication to acused the death. Do not enter the mode of dying, such as cardiac	ns Mortu nnapolis or respiratory arrest	Md. 21401 Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Interval Between Onset and Death
	Examiner		Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	luve	
1760,	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):		
Box 68	certifica ding ph se as th	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
P.O. Bo	that the death certifica ed by the attending ph detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown		Month Day Year
	requires that been signed to hould be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Munknown
Division of Vital Records,	The law re te has bee bage 2 sho	Completed		24a. Was an autopsy performed	
Vital	Physician: this certifica ral director, p	Be	examiner?   Hospital: Other	h (Check only one)	
on of	ling Physi I. After this c	ion: To	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?	me 5 Residence 28d. Describe how	e 6 □Other (Specify) injury occurred
)ivisid	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	nt and Number or Rural Route Number, state)
_	Hospital 24 hours Funeral etely filled	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 mand manner stated.	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the	Me	29b. Signature and title, of pertifier  29c. License number	29d.	Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (frem £3a) (Type, Print)		11004
(n=				eneral	405pital
RY	Sta Regist		31. Date filed (Month, Day, Year)  APR 2 1 2004		

		For	State of Marylan	d / Depa	artment of	Health ar	nd Mental Hy			11 (27
		1 - State Registrar		Cei	rtificate o	f Death		Reg. No.	2004	14627
Physic	cian	1. Decedent's Name (First, Middle, Las	1)				2. Date of De Month April	Day	Yeer 2004	3. Time of Death
/Med Exam		Betty Ann Peck  4a. Fecility Name (If not institution, give	street and number)		4b. City, Town	, or Location of			County of Deeth	
Exam	iner	Anne Arundel Medi			Annapo			Ann	e Arund	e1
Funera Directo		5. Social Security Number 6. Se 458-22-6483	7. Age (In yrs. I		If Under 1 Yes Months Day		Min.  8. Date of Bir (Month, De Feb. 12	th by, Year) 19	9. Birth Col Cal	plece (State or Foreign intry) 1 To rnia
and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
Maryl -f eho	to	Maryland Anne Aru	ndel Armo	ol d						1 ☐ Yes 2 No
th the or 28s	Directo	10e. Street and Number			10f. Zip Code	9		10g. Citiz	en of What Cou	intry?
ath wi		576 Shore Acres			21012				ed Stat	
If y I and Z I Z I D-UUSO should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "naturat", or Items 23a or 28s-f show amelic event, I'ra hedical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C		n? (Specify Yes or No Puerto Rican, etc.)	1	4. Race - Amer Black, White Specify: wh	
2 hou	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occ kind of work do	cupation	of working	16b. Kin	d of Business/I	
iffin 7	Completed	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use ret	ired)	or working	-		
Maryland 21215-UU36 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other than "natural; or traumatic event, the Medical Exem		17. Father's Name (First, Middle, Last)	2	Sys	stems Ar		s Name (First, Middle,		ctronic	S
Z da by	Be	Albert Herman					Blalock	. Maiden S	ourname)	
re, Maryla s 1 and 2 should f Health and Men item 27 is marke other traumatic	7	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Stre		or Rural Route Numb	er, City or	Town, State, Zi	p Code)
		Keith Peck/ son		565	Shore A	cres Ro	ad Arnold,	MD :	21012	
altimore, M rmit. Pages 1 and 3 partment of Health portant: If Item 27 y injury or other tr	1	20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	lace of Dispo	sition (Name of natory or other p	olace)	Date	20c. Loc	ation - City or T	
Pages tment of tant: If it igury or o		*4 □ Donation 5 □ Other (Specify	Arl				4-27-04	Arl:	ington,	VA
Baltimor permit. Pages Department of Important: If it any injury or or		21. Signature of Funeral Service Licens	Romenstu	14	2. Name and Add	of Glou	cester St.	Anna		1 Home, Inc
	8	23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the death one cause on each line.	n. Do not ent	er the mode of d	tying, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medica		Immediate Cause (Final disease or condition resulting in death)	a. Lyte	Clark	4-					0.130( 4.10 004.11
Examine			Due to (or as a consequ	uence of):	7 0	/				
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os fou, ficate be executed physician and is the burial-transit	Examiner	that initiated events	c. Neutro	A Carida	m					
/ bU, le be executed /sician and e burial-transit		resulting in death) Last	Due to (or as a conse	ence of):						
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necords, F.O. box box The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as thi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23	3d. Date of deliv	erv
death death death death	iclar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnar Other (specify)				Month	Day Year
that the de detached to detached to	hys	9 🗆 Unknown	9□ Unknown							
S, T res tha signed be det	b	Part II. Other significant conditions co	,	ulting in the u	nderlying cause	given in Part I.	T T			the cause of death?
w require	eted	- rung u	inll				_			
HECOLOS, he law requires t e has been signe	Completed						24a. Was autop		24b. Were auto prior to co death?	opsy findings available ompletion of cause of
	ပိ	25. Was case referred to medical				ac Diese e	1 ☐ Yes		1 🗆 Yes	2□ No
	To B	examiner?	Hospital: 1 Inpatient 2 🗆	ER/Outpatien	t 3 DOA	Ther	ing Home 5 Resid	Distres.	Other (Speci	fv)
O ₹ ₹ @		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. In		28d. Describe I			,,
Attending r death.	catio	2 Accident investigation			M 1	☐Yes 2☐No				
INISION  or Attending after death. Director: After	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, offic	×8	28f. Location (S City or Tov	Street and vn, State)	Number or Run	al Route Number,
D1V  To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by		29a. Certifier 1 Certifying Phy	ysician: To the best of my know	wledge, death	occurred at the	time, date and	place, and due to the	cause(s) a	nd manner as s	stated.
n 24 h	Medical	(Check only 2 Medical Exam	iner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in m	y opinion, death	occurred at the time,	date and p	place, and due t	o the cause(s)
To the within To the comp	Ž	29b. Signature and title of certifier	-// .			ense number	,	29d. Date	signed (Month,	Day, Year)
		Center	Ham	MO	0	5330	26	41	21/01	
		30. Name and address of person who o	ompleted cause of death (Item	23a) (Type.	Print)	110	4	1	0. 4. 1	5 mg 2189
	tate	31. Date filed (Month, Day, Year)	32. Engistrar's Signal	lure //	7416	r-0 >	15 711	inn	9/10/1	s uno 2189
Regis		APR 2 6 2	004	1 4	hack)					

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jos**e**ph L. Pierzga April 2004 11:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1502 N. Riverdale Drive Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year **Funeral** 347-22-3357 73 2, Ill inois Director Aug. 1930 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show r than "natural", or items 23a or 28e-f show the Wedleal Examiner must be notified at 1 ☐ Yes 2 PNo Maryland Anne Arundel <u>Annapolis</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 United States 1502 N. Riverdale Drive Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ® Yes 2 □ No
If Yes, Give 1951-1955 1 □ Yes 2 No
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Specify. þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Engineering other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked othe any injury or other traumatic event, QDCs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Pierzga Katarzyna Madon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Pierzga/ wife 1502 N. Riverdale Dr. Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 4-23-04 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Cancer months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, they, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Box 68760, Physiclan/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the o 9 Unknown 9 Unknown Division of Vital Records, P. signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death Check onl ne Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: d in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16964 4/22/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Chaconas 1509 Ritchie Highway Arnold, MD 21012 31. Date filed (Month, Day, Year) 32. Proistrar's Signature State APR 2 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2001 1 - For State Registres Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) April 20, Day 2004 **Physician** 6:00 A. M Konstantinos D. Papagiannakis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomerv Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months 1[**Ž**M 2□ F 83 579-66-0204 Director Mar. 21, 1921 Greece Usual Residence of Decedent the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow ampiry or other traumatic event, the Marical Examination of the real motified at once. 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Washington Director D.C. 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 20015 USA 4112 Jenifer St. NW. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bartender Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Trene Stamatelou Dimitrios Papagiannakis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5301 Bradley Blvd., Bethesda, Md. 20814 Steve Gaginis/nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition b 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 4/26/2004 Silver Spring, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc., 5130 21. Signature of Funeral Service Licensee 2 Wisc. Ave., NW., washington D.C. 20016 23a. Part1. Enter the obsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Pneumonia 2 days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (2) leaded of linery Due to (or as a consequence of): Examiner burial-transit Cause (Disease or Inju-that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 requires that the death certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Dementia Completed Congestive Heart Failure 24b. Were autopsy findings available prior to completion ci cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ë P 1 ☐ Yes 2 🔀 No Division of this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or within 24 hours after To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D37891 April 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD., 121 Congressional Ln., #409, Rockville, MD. 20852 Amit Rajvanshi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State oaks 2004 APR 22 Registrar

DHMH 17 Rev 1/200

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20/04 0600

State of Maryland / Department of Health and Mental Hygiene 2001 14630 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 1560 SUSIAN M. PRUSIGE **Physician** leof MORA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BUTTESTOA MOUTGOWERY SUBUYLBUSY HOSPITTE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 TF Yrs. 1950 Pennsylvania March 9, 54 Director 199-36-1632 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 2 should be filed within 72 mounts and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show 7 is marked to 10 in 1 Yes 2 No Directo Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20817 United States 22 Holly Leaf Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Lawyer other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Florence Leiber Fingeret David 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 ls any injury or other trau 22 Holly Leaf Court, Bethesda, MD 20817 Steven Paysner, husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 20a. Method of Disposition 4/20/2004 Shaler, Pennsylvania Beth Shalom Cemetery 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20052 Jace My free 23a. Part. Enter the states, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. HETERIOSCICIANTIC CHROIDUNSCULIAR DISONSE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed inding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t lirector, page 2 s autopsy performed? 1 Yes 2 No 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? examiner? 1 □Xes 2 □ No Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (OME) w.0. 015236 APARIL Lb, 2004 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IIILS FORWARD Prior, ROGENTUS, MO 20952 CHELL I. MARGOLI, MO. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 20 2004 souks Registrar

DHMH 17 Rev 1/2001

Pavsner, Susan

		For State C	of Maryland / De	epartment of Ho Dertificate of L	ealth and Me Death	ntal Hygien Reg. N		14631	
Physicia		Decedent's Name (First, Middle, Last)  Charles	Pennewell			Date of Death Month Da April 17,	ay Year	3. Time of Death	
/Medic Examine		4a. Facility Name (If not institution, give street and nu Anchorage Nursing & Reha	mber)	4b. City, Town, or Salisbu	Location of Death		c. County of Death		
Funeral Director		5. Social Security Number 6. Sex 1 M № 2 ☐ F	7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year Coember 11,	9. Birth	place (State or Foreign ntry)	
Maryland -1 show	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o					10d. Inside City Limits 1	
with the 3a or 28a	Funeral Director	Maryland Wicomico  10e. Street and Number  105 Times Square	Salisu	10f. Zip Code		10g. C	3. Time of Death  Year  2004  8:20 AM  Country of Death  Wicomico  9. Birthplace (State or Foreign Country)  1940  Maryland  10d. Inside City Limits 1 Yes 2 No  izen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  Ind of Business/Industry  N/A  Sumame)  Be Bratten  Town, State, Zip Code)  Claware 19951  cation - City or Town, State  Lisbury, Maryland  cional Association  Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  Se contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  S Other (Specify)  Toccurred  A Number or Rural Route Number,		
S S S	þ		orces? 2 MNo ve	13. Was Decedent of His	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify:	etc.	
Z1Z15-0036 d within 72 hours at giene. ar than "naturel", or the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (	1-4or 5+)	ecedent's Usual Occupa Bive kind of work done d fe. DO NOT use retired)	uring most of working	16b. F	6b. Kind of Business/Industry		
S d ii b	To Be Co	N/A 17. Father's Name (First, Middle, Last)  Frank Harry Penner		/A	18. Mother's Name (	First, Middle, Maide Florence	n Sumame)	atten	
Na nd 2 s ith ar ith ar 27 ls r treu	<u> </u>	19a. Informant's Name/Relationship (Type, Print) Thelma Stevens (siste	19b. M	Mailing Address (Street a	nd Number or Rural F	Route Number, City	or Town, State, Zip	Code)	
Baltimore, IN semit. Pages 1 and 2 Department of Health importent: If Item 271 sity injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of D cemetery,	isposition (Name of crematory or other place try Cremator	Dat	9 20c. L	ocation - City or To		
Baltimore permit. Pages 1 Department of H Importent: if Ite eny injury or ott		21. Signature of Funeral Service Licensee	CEIP	22. Name and Address Holloway F	s of Facility Funeral Hor	me Profes	sional As	sociation	
Physician /Medical		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on disease or condition resulting in death)	caused the death. Do not sach line.  ASCVD  (or as a consequence of)					Approximate Interval Between	
Examiner	Jer	Sequentially list conditions, b. Due to	(or as a consequence of)						
58 760, ficate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to	(or as a consequence of)						
Geath certil	Physician/Med	in the cast 13 months?	tcome of pregnancy birth 2  Fetal death nant at time of death own	3 Ectopic pregnancy 5 Other (specify)				•	
	þ	Part II. Other significant conditions contributing to d	eath but not resulting in th	e underlying cause give	n in Part I.	23e. Did tobacco			
	Completed					24a. Was an autopsy performed?	prior to con death?	inpletion of cause of	
Of VITA Physician rthis certifu	To Be	27. Mangrer of Death 28a. Date	Inpatient 2 ☐ ER/Outpa	atient 3 DOA Other	at 280	Check only one)  5  Residence  d. Describe how inju		()	
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	th, Day Year) Inju of Injury - At home, farm ng, etc. (Specify)	ry Work' M 1 □ Y	? es 2 □ No		nd Number or Flura	l Route Number,	
DIVI To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical Ce	29a. Certifier  (Check only one)  (Check only one)	best of my knowledge, d asis of examination and/o ner stated.	eath occurred at the time or investigation, in my opi	e, date and place, and inion, death occurred	d due to the cause(s at the time, date an	) and manner as st d place, and due to	ated. the cause(s)	
To the within To the comple	Me			29c. Licensa	number	29d. Da	te signed (Month,	Day, Year)	
		30. Name and address of person who completed cause	se of death (Item 23a) (Ty	pe, Print)  UTH DIVISK	ON 5T.,	5 AL 53	chy MD	2/804	
Stat Registra	e ir	31. Date filed (Month, Day, Year) APR 2 0 2004	legistrar's Signature	5 Spork					

		1	1- State of Maryland / Depar Ragistrar Certification	tment of Health and M ificate of Death		2004	14632
	<b>5</b> 1	_	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Esther L. Panitz			11 2004	01:15 A <sup>M</sup>
	Examin			4b. City, Town, or Location of Death		4c. County of Deat	h
				Annapolis If Under 1 Year   If Under 24 Hrs.	C. Data of Sinth	Anne Aru	
	Funeral Director		1 ☐ M 2 ☑ F	Months Days Hours Min.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign untry)
		-	137-46-1884 82 Yrs.  Usual Residence of Decedent		March 9,	1922 New	York
	show		10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
	e-f	cto	N.Y. Westchester Shrub Oak			,	1 ⊠Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
	ath w	<u>ra</u>	1204 Williams Drive	10588		USA	
	er de	Funeral	Armed Forces?	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	oy F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 ☑  3 ☒ Widowed 4 □ Divorced Year or Dates:	Yes 2 No Specity:		Specify: Wh	ite
5-0036	filed within 72 hours after death with the Maryland Hygiene. Ather then "neturel", or Items 23a or 28e-f show ant, the Maxical Examitter coust be notified at	Completed by	15 Decedent's Education 16a Decede	nt's Usual Occupation	16	6b. Kind of Business/	Industry
215	nin 72	be	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give ki	nd of work done during most of worki O NOT use retired)	ng		
2121	d with	E		ish Professor		Education	
p	be file tal Hy d othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Va Ia	should b ind Menti is marked umatic e	2	Robert Allentuck	Gittel	Halkin_		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiens. Internet, or Items 23a or 28e-f show importent: It item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumatic event, Ite Maxical Examinational be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rura	l Route Number, (	City or Town, State, 2	(ip Code)
	and lealth m 27 her tr	-		enessee St. Annap			Tours Chair
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State	tory or other place)		c. Location - City or	rown, State
Ë	t. Pa Itmen Itent: ijury	1	'4 □Donation 5 □Other (Specify)   Cedar Parl		5/04 E	merson, N.	J.
Bal	permit. Departr Importe any inju			Name and Address of Facility LIS Suburban Chap -01 Broadway Fair	els, Inc		
	10144	-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter			1	Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final			"	Interval Between Onset and Death
	Physician   /Medical		disease or condition resulting in death)  a.   Due to (of as a consequence of):	pneumoi	214		
	Examiner		Dusphan	ica			
		ē	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury	100			
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	7			
o,	an an rial-tr	Ex	resulting in death) Last ue to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	Completed by Physician/Medical	d.				
39 )	antifica ing pl	Med	IF FEMALE:	10.00			
Вох	death certific e attending p id for use as	lan/	23b. Was decedent pregnant in the pact 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	ctopic pregnancy		23d. Date of deli Month	very Day Year
0	the a	sic	1 ☐ Yes 2 No 9 Unknown 9 Unknown	Other (specify)			•
<u>a.</u>	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as I	F	Part II. Other significant conditions contributing to death but not resulting in the und	lerlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	signe d be	db			1 🗌 Yes	2 □ No 3 □ Pro	obably 4 Onknown
Ö	w requir been si should	ete			24a. Was an	24h Wara au	toney findings available
Rec	ne lav n has ge 2:	du			autopsy	d?   death?	topsy findings available completion of cause of
a	n: Th fficate or, pa		25. Was case referred to medical	26. Place of Death		/No 1 ☐ Yes	2 No
Ξ	Physicien: this certific ral director,	To Be	examiner?  1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	Other		ce 6 □Other (Spec	vi6u)
Division of Vital Records,	Ing Physicion: The lav After this certificate has uneral director, page 2		27. Manner of Denn 28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how		ony)
on on		ation	1 Xatural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work?/ M 1 ☐ Yes 2 ☐ No			
S	I or Attency after death Director: I in y the	Hic	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	ot, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
Ö	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in y the	Certification:	Salaring, etc. (Specify)				
	Hospitel 24 hours a Funerel I	edical	29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or inve				
	the H vin 24 the F nplete		one) and manner stated.				
		Σ	29b. Signature and title of certifier	29c. License number	y 290	Date signed (Month	i Doy, rear)
1	0		They mis.	100/03		TOril	12,004
			30. Name and address of person who completed cause of death (ltegr 33a) (Type, Pr		Hersvil	le mi	Dalle
$\mathcal{D}_{\blacksquare}$	- Ct-	to.	31. Date filed (Month, Day, Yeer) 32. Registrar's Signature	DIJIJIMUY 11	HELDY!	14/11	201100
\	Sta Registr		APR 13 2004	Sparke			

Panitz, Esther 700:4/11/04

State of Maryland / Department of Health and Mental Hygiene 200 L 14633 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:05 PM Robert Stuart Parker, Sr. April 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Montgomery 01ney Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 □ F 1933 579-40-8100 Washington, DC Director 70 Usuel Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic avent, the Modical Evending I are profitted at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 DINo Directo Maryland Montgomery 01ney 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Roseneath Street 20832 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 257 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2K No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber 12 Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James E. Parker Evelyn M. Stuart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ann Parker/ Wife 3800 Roseneath Street, Olney, Maryland 20832 Baltimore, 20b. Place of Disposition (Name of April 13, 20c. Location - City or Town, Stete 20a. Method of Disposition Gate of Heaven 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ▶ G-KenSkiles Francis J. Collins Funeral Home Inc. 500 University Blvd. W.,Silver Spring, MD 20901 23a. Pagh. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Massive Hemoptysis 30 Minutes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coagulopathy 1 Week Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed nding physicien and use as the burial-transit Hepatitis C Liver Disease 20 Years Due to (or as a consequence of): Box 68760 Completed by Physician/Medical nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death hed by the atter 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute Myocardial Infarction 1 Yes 2 No 3 Probably 4 Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 2 No 1 TYes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 2 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death s after dec. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 Homicide within 24 hours a To the Funsral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of confider 29c. License number 29d. Date signed (Month, Day, Year) ochen 10 D26540 April 7, 2004 30. Harrie and address of person who completed cause of death (Item 23a) (Type, Print) Carl I. Schoenberger M.D. 16220 Frederick Road, Gaithersburg, MD 20877 31. Date filed (Month, Day, Year)
APR 1 2 2004 32. Registrar's Signature State Departies. oaks Registrar

			State of Maryland / Department of Health and No.  1 - State Registrar  Certificate of Death		2004 14634
	Physici		1. Decedent's Name (First, Middle, Last)  Dall as Parkson	2. Date of Death Month	Pay Year 3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give street and number)  Anne Armael Medical Corter Amapolis		4c. County of Death Anne Arundel
E	Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Mark 1 Security Number 224-05-3580 1 Mark 2 F 84 Yrs. 1 Months 1 Days Hours Min.	8 Date of Birth (Month, Day, Y	(ear) 9. Birthplece (State or Foreign Country) Virginia
	show	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ᡚ No
	or 28a-1	Director	Maryland Anne Arundel Crofton  10e. Street and Number 10f. Zip Code		. Citizen of What Country?
	ath wi		1672 Carlyle Dr. Apt B 21114		nited States
920	hours after death with the Maryland tural', or flams 23a or 28a-f show al Examinar must be notified at	by Funeral	11. Marital Status  1  Never Married 2 Married  1  Never Married 2 Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes, Sive Year or Dates: 1963	o Rican, etc.)	Black, White, etc.  Specify: white
21215-0036	n 72	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5_  Attorney	king	b. Kind of Business/Industry
d 2.	filed with Hygiene. other ther			ne (First, Middle, Ma	
Maryland	Mental Mental arked c	To Be	Ollie M. Patterson Gazelle		laverstack
Mar	d 2 shoul th and Me 7 Is marl traumati		19a. Informant's Name/Relationship (Type, Print)  Sadie Patterson/ wife  19b. Mailing Address (Street and Number or Ru  19c. Mailing Address (Street and Number or Ru  19c. Mailing Address (Street and Number or Ru		
a)	of Health item 27 I		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery crematory or other place)	Date 20	c. Location - City or Town, State
Baltimore,	Page tment c tant: If jury or		THE CHOULDE OH; OCM;	The second second second	nerando, Virginia
Ball	permit. Pages 1 Department of F Important: If ite any injury or of		21. Signature of Fymeral Septimental Septi	, Waynesbo	oro, VA 22980
	Physician /Medical Examiner	ner	23a. Pard. Enter Me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  The first light disease or complications are separately contained by the conditions.  The first light disease or complications are sequenced by the conditions.	or espiratory arresi	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	ledicai Examin	d	ease	
.O. Box	at the death certifice by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   1   Live birth 2   Fetal death   5   Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	es this gned be de	by	Part II. Other significant containing commonling to beautiful resulting in the underlying cause given in Part I.		2 No 3 Probably 4 Unknown
I Records,		Completed		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Vital	ician: certific	Be	25. Was case referred to medical axaminer?	th (Check only one)	
of		n: To	To yes 20 No 11 Inpatient 2 LEN/Outpatient 3 DOA 4 Nursing H	ome 5 Resident 28d. Describe how	ce 6 Other (Specify) injury occurred
Division	I or Attending I after death. Director: After d in by the funer	Certification:	1	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Ω	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Cer			
	To the within 2 To the comple	Med	29h Signature and title of Attitier 29c. License number	29d	. Date signed (Month, Day, Year)
	6		DS8922	(	418104
) _	-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Michael (ee Ane Anela Mehical Cent	er, Annap	4/8/04 I medical Perking polis, MD 21401
	Sta Regist		31. Date filed (Month, Day, Year)  APR 1 3 2004  32. Registrar's Signature  Apauls		

		1 - For State Registrar	State of I	viarylan		artment of rtificate o				giene, leg. No.	2001	1 146:
		Decedent's Name (First, Middle, I	Last)						2. Date of Dea	ıth		3. Time of De
hysici /Medio		Yoland	a I	Piowat	v				Month April	Day	2004	5:25 H
xamir		4a. Facility Name (If not institution, g				4b. City, Town	n, or Location	n of Death			ounty of De	
		Collingswood Nu	rsing Cent	ter		Rock	ville			M	ontgor	nery
neral		,	. Sex 7. 1 ☐ M 2 🔀 F		last birthday)	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Bi	rthplace (State or Fo
ector		192-01-5953	10 W 2821	86	Yrs.				July 7,		7	PΆ
**		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City L
le pai	ō	Maryland Montg			0.11	a .						1 ☐ Yes 25
the Medical Exeminer rust be notified at	rec	Maryland Montg	omery		silver	Spring				IOn Citize	en of What C	Country?
3	<u> </u>	932 Venice Drive	•							•		,
# 5	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13. V	209 Was Decedent	of Hispanic C	Origin? (Spi	ecify Yes or No-		ited S	STATES Jerican Indian,
	Ē	1 ☐ Never Married 2 ☐ Married		f Yes, specify C	uban, Mexic	an, Puerto	Rican, etc.)		Black, Wh			
Exa	b	3 ₺ Widowed 4 □ Divorced	If Yes, Give Year or Date	s:	1	I⊡Yes 2⊠i	No Specifi	y:		S	pecify:	White
lical	Completed	15. Decedent's (Specify only highest of	Education			lent's Usual Oci kind of work do		ant of work		16b. Kind	of Business	
*	npie	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	DO NOT use ret	tired)	ISLOI WOIK	ng			
4	Cou	8			Child	Care W	Vorker			Ch	urch	
evant,	Be	17. Father's Name (First, Middle, La	st)				18. Mot	her's Name	(First, Middle, I	Maiden S	u <i>mam</i> e)	
	2	Samue1	0	anello					Marie		Mario	
rauma		19a. Informant's Name/Relationship	. ,, . ,		19b. Mailin	g Address (Stre	eet and Numi	ber or Rura	l Route Number	, City or T	Town, State,	Zip Code)
r other traumatic		Carmen Withers/S	ister					14.5	kville,	Mary	land	20850
olo		20a. Method of Disposition 1   Burial 2   Cremation 3	☐Removal from Sta		lace of Dispos emetery, cren	sition (Name of natory or other p	olace)		ate	20c. Loca	ation - City or	Town, State
CAN	1	'4 □Donation 5 □ Other (Spec				eaven C		4/12	/2004	Silve	r Spr	ing, MD.
any injury or of		21. Signature of Funeral Service Lie	enseen O	00.	22	. Name and Add	dress of Faci		Vol Fune			
2 G		Machine	Die		u 10	East De	eer Pa					MD. 20877
s the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	mers I	rence of):	La						
tached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	d.  23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3 🗌	Ectopic pregnar Other (specify)				230	d. Date of de Month	livery Day Year
pa	þ	Part II. Other significant conditions	contributing to death	but not resu	lting in the un	derlying cause	given in Part	l.		acco use s 2忆1		o the cause of death robably 4 DUnkne
2 should	ompleted								24a. Was ar	1 2	24b. Were au	utopsy findings avail
rector, page 2	E								autopsy	y ned?	prior to death?	completion of cause
	0	25. Was case referred to medical					26 Plac	e of Death	(Check only one		1 Li Yes	2 □ No
director,	OB	examiner? 1 □ Yes 2🏡 No	Hospital: 1 ☐ Inpa	tient 2 🗆 E	R/Outpatient	3 DOA		- 1100	ne 5 ☐ Reside		Other (Sne	cifu)
<u>a</u>	n:T	27. Manner of Death	28a, Date of In		28b. Time of	28c. In	jury at		8d. Describe ho			City)
e funera	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati		Jay (Gai)	Injury		łork? □Yes 2.⊑	]No				
d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Flace of I	njury - At hor etc. (Specify)	me, farm, stre	et, factory, offic	е	2	8f. Location (Str City or Town		lumber or Au	ural Route Number,
₩	edical (	29a. Certifier 1  Certifying F (Check only one) 1  Medicel Exe	Physicien: To the beseminer: On the basis and manner	of examination	vledge, death on and/or inve	occurred at the estigation, in my	time, date ar y opinion, dea	nd place, a ath occurre	nd due to the ca d at the time, da	use(s) an	d manner as ace, and due	stated. to the cause(s)
oletely fi		29b. Signature and title of certifier.	^ _			29c. Lice	nse number		29	d. Date s	igned (Monti	h, Day, Year)
completely fi	Me					1						
completely filled in by the	Me	· Allah				חת	1058961	2		12241	0 2/	<b>10</b> /4
completely filled	Me	30. Nam and address of person who	o completed cause o	death (Item	23a) (Type. P		058962	2	A	April	9, 20	004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 11, Charles Sumner Po1k April 9:01 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing and Wellness Center Rockville Montgomery 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 X M 2 □ F New York 081-22-5670 75 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5809 Nicholson Lane, #307 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Kyes 2 □ No Korean If Yes, Give Year or Dates: Conflict Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Aaron McLoughlin Polk Justina Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennie M. Polk/ Wife 5809 Nicholson Lane, #307, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 13. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium, Inc. 2004 Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee Ungelette Bannis M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myelodyplastic Syndrome disease or condition resulting in death) Due to (or as a consequence of): Hepatic Failure Due to (or as a consequence ol) Iron Overload Secondary To Multiple Transfusions Due to (or as a consequence of): Thrombocytopenia 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

use as the burial-transit

detached signed by the

should be

peen

certificate

After

within 24 hours after death. To the Funerel Director: A

funeral

and

attending physician

The law requires that the death certificate be exe

To the Hospitel or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

Be

2

Certification:

**Physician** 

/Medical

Directo

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Completed

Be

Examiner

**Funeral** 

Director

item 27 is marked other than "natural", or Items 23a or 286-f show other treumatic event. If a Modical Exercise must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other firsh "n any injury or other treumatic event, If a Mad once.

with the Maryland

death

hours after

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 😾 No

27. Manner of Death

1 X Natural

2 Accident 3 Suicide

4 Thomicide

29a. Certifier

autopsy performed? 1 ☐ Yes 2 💢 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) 3□ DOA

Other: 4X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature title of certifier

investigation

determined

6 Could not be

5 Pending

29c. License number D59284

29d. Date signed (Month, Day, Year) April 12, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

1299 Lamberton Drive, Silver Spring, Maryland 20902 Shahid Shamim, M.D.

2 ER/Outpatient

28b. Time of

State Registrar

3+1

31. Date filed (Month, Day, Year) 2004 32. Registrar's Signature



	1	For State Registrar	State of Maryla		artment of H			giene Reg. No. 200	4 1463				
nysiciai	n	Decedent's Name (First, Middle, Last)  Daniel Walter Pask			-		2. Date of Dea Month April	Day Year 12, 2004	3. Time of Death				
Medica xamine	r '	419 Fernwood Drive 5. Social Security Number 6. Sep	<u> </u>	rs. last birthday)	4b. City, Town, or Severi	r Location of Dea na Park If Under 24 Hr	s. 8. Date of Birth	4c. County of Dea	rundel thplace (State or Foreig				
neral ector		214-20-5677  Usual Residence of Decedent	ZM 2□F 70	6 Yrs.	Months Days	Hours Mir	July 2,	r, Year) Co	aryland				
ne notified at	ctor	MD Anne Arur		City, Town or Lo Severna	Park				10d. Inside City Limi 1 ☐ Yes 2 ☑ N				
To act is	al Dire	10e. Street and Number 419 Fernwood Driv	<i>7</i> e		10f. Zip Code 2114	б		10g. Citizen of What Co USA	ountry?				
	by Fur	11. Marital Status  1 Never Married 2 Narried  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: W		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.				
nan natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wi d)	orking	16b. Kind of Business Martin Ma					
marked other than	To Be Co	17. Father's Name (First, Middle, Last) Peter Paska	4		Councaire	18. Mother's Na Anna H	ame (First, Middle,		штесса				
reumat reumat	-	19a. Informant's Name/Relationship (Ty Daisy Paska/Wife			ng Address (Street			r, City or Town, State, a Park, MD					
ry or other i	n	20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ F  1 □ Donation 5 □ Other (Specify)	Removal from State	b. Place of Dispo cemetery, cre-		ce) Apr	Date Cil 15	20c. Location - City or Crownsvill	Town, State				
Importent: If I any injury or one once.		21. Signature of Fineral Service Licensee  22. Name and Address of Facility Barranco & Sons, P.A. Severna Park I 495 Gov. Ritchie Hwy. Severna Park,  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
sician edical miner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the done cause or each line.  a.  Due to (or as a con	TATIC	ter the mode of dyin	g, such as cardi	ac or respiratory and	NOMA	Approximate Interval Between to et in Death				
	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con  c. Due to (or as a con  d.										
ed by the attending phi detached for use as th	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	y		23d. Date of de Month	Blivery Day Year				
ig pe	۵	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	underlying cause giv	ren in Part I.		obacco use contribute t ⁄es 2 □ No 3 □ P	o the cause of death				
ate has page 2	Completed							an 24b. Were a prior to death? 2 No 1 Yes	utopsy findings availa completion of cause s 2 \( \square\) No				
certific rector,	o Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA Ott		eath <i>(Check only o</i>		ecify)				
5 =	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		of 28c. Injur			now injury occurred					
Director:	Certification:	3 Suicide 6 Could not be determined	building, etc. (Sp	pecify)			City or Tow		lural Route Number,				
E S			ce, and due to the o	the cause(s) and manner as stated. me, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)									
To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one)  1☐ Certifying Phy 2☐ Medical Exam 29b. Signature and title of eenifier	iner: On the basis of exam and manner stated.	mination and/or in	29c. Licens	se number			e to the cause(s)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Blanche Adele Perry April 22 9:00 a<sup>M</sup> 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 302 Crusader Arms Apt. 102 Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 X F 217-10-8996 87 Director Aug. 10,1916 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location rthan "nstural", or Itama 23a or 28a-f show the Medical Examinar most be redified at 1 XYes 2 □ No MD Dorchester Director Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Crusader Arms Apt. 102 21613 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white À 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) line worker tuna processor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othing any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William J. Horner Emma Sinclair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonja Kozak daughter 308 Crusader Apt. 201, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 4/25/04 Cambride, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD Sriem K. Dut 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lips. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ar 5 minute resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes SPNo 25. Was case referred to medical examiner? 1 🗌 Yes 2€-No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of hath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and file of certifier 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Byrn St Cambrie 31. Date filed (Month, Day, YAPR 26 State Registrar

		1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	rtment of H tificate of L		ental Hygien	2004	14639
Phys /Me	ician dical	Decedent's Name (First, Middle, La Barbara A	st) nn Powley				2. Date of Death  Month  April 20		3. Time of Death  0800 A M
Exan	Ų		GENERAL 7. Age	HOSPITAL (In yrs. last birthday)	CAMBI If Under 1 Year	RIDGE If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	STER_ place (State or Foreign ntry)	
Directe		Usual Residence of Decedent	I□M 2 <b>X</b> F	62 Yrs.	Months Days				ryland
Maryland  a-f show	ctor	MD 10b. County Dorches	ter	10c. City, Town or Lo	cation Winga	ate			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with the ms 23s or 28s.	Funeral Director	10e. Street and Number 2153 Wingate B	ishops Head	l Road	10f. Zip Code	21675	10g. C	itizen of What Cou	intry?
<u> </u>	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	, etc.
ind 21215-0036 be filed within 72 hours aft after Hygiene and do other than "natural", or event, the Madical Exami	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ade completed)  College (1-4or 5-	(Give	ent's Usual Occupa kind of work done of DO NOT use retired, homemake	uring most of workir	ng	own home	
	To Be	17. Father's Name (First, Middle, Last Ralph Wilson Sl	acum			Agnes Cl			
re, Marylas 1 and 2 should 1 Health and Mer Item 27 is marks othar traumatic		19a. Informant's Name/Relationship Beverly Tippett  20a. Method of Disposition	daught		Tred Avor	n Ave., Ea	Aston, MD	21601	
Page: nent o ant: If		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Speci	(y)	East New	natory or other place Market Ce	emetery 4,	/23/04 Ea	ocation - City or T st New Ma	arket, MD
Balt permit. Departi Importa	ODCE	21. Signature of Funeral Service Lice	ita	7	00 Locust	St., Can	omas Funer Abridge, M		P.A.
Physicia /Medica Examine	al er	23a. Pant1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Ay ter  Due to (or as a	the death. Do not entered to SC /E /O for a consequence of):					Approximate Interval Between Onset and Death Jess Jess
18760, icate be executed physician and s the burial-transit	dical Examine	that initiated events resulting in death) Last	c.  Due to (or as a	consequence of):					
P.O. Box 6i that the death certific ed by the attending p detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
ords, P requires that een signed b nould be deta		Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	derlying cause give	n in Part I.	23e. Did tobacco 1 ☐ Yes 2		he cause of death?
I Rec The law ate has b	Completed						24a. Was an autopsy performed?	death?	opsy findings available impletion of cause of
of Vital F Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatier		3 □ DOA Othe	4   Nursing Hon	ne 5 ☐ Residence		(y)
Jing After funer	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	e Ope Place of Inju	Year) Injury ry - At home, farm, stre		? ′es 2 □ No	8d. Describe how inju 8f. Location (Street a City or Town, Stat	nd Number or Run	al Route Number,
ppita ours peral	edical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best o miner: On the basis of and manner stat	examination and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurre	nd due to the cause(s d at the time, date an	s) and manner as s nd place, and due t	stated. o the cause(s)
To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	Genry r	A1)	29c. License	number 17924	29d. Da	ate signed (Month,	Day, Year) O G
		30. Name and address of person who NOMAN THAN 1		sath (Item 23a) (Type, I AURORA s Signature	STREET	CAMA	RIDGE	MD 2.	1613
	State strar	31. Date filed (Month, Day, XPR	2 Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	days K	booth				

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	Physici /Medic		Decedent's Name (First, Middle, La Nancy Lee P	ritchett							2. Date of Dea Month April	C				
	Examin		4a. Facility Name (If not institution, gir						Location o	of Death			c. County of	Death		
F	uneral		Mallard Bay Ca 5. Social Security Number 6.3		e (In yrs.	last birthday)	If Und	embri	If Under		8. Date of Birt	h .				or Foreian
	irector		210-74-4991	1 □ M 2 💢 F	69	Yrs.	Months	Days	Hours	Min.	June 1	y, Yea 7 <b>,</b>	1934	Ma	rylan	d
land	Mo III		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	Od. Inside C	City Limits
Many	e-f sh	tor	MD Dorches	ster				Ca	ambrio	ige					1 XYes	2 □ No
death with the Maryland	Se or 28	Director	10e. Street and Number 208 Meteor Ave.	#504			10f. Z	ip Code	21613	3		•			try?	
death	rms 23	Funeral	11. Marital Status	12. Was Decedent I	Ever in U	.S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							Americ		
ours after	Department or result and wonline rygener.  Department or result and wonline rygener.  By injury or other treumatic event, the Nacional Exertment must be redified at 900s.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  Armed Forces?  If Yes, Give Year or Dates:	10		1 ☐ Yes 275 No Specify:						Specify:			
12 h	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Us	ual Occupa	ation during mosi	of worki	ing	16b.	Kind of Busi	ness/Inc	lustry	
within	r then	ошо	Elementary/Secondary (0-12)	College (1-4or 5	+)	1000		ot wo					nor	)e		
	d othe	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Reg. No.  Day Year 1:30 a. M  4c. County of Death Dorchester  The Day Year 1:30 a. M  4c. County of Death Dorchester  The Dorchester 9. Birthpace (State or Foreign Country) Maryland  10d. Inside City Limits 1  Yes 2  No  10g. Citizen of What Country?  U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry  none  Maiden Sumame)  16c. City or Town, State, Zip Code)  19973  20c. Location - City or Town, State  Cambridge, MD  Uneral Home P.A.  MD 21613  Trest, Approximate Interval Between Onset and Death 2  23d. Date of delivery Month Day Year  Obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Durknown  an Symptomic Country or Town of Country or Completion of Cause of death?  1 Yes 2 No 3 Probably 4 Durknown  an Symptomic Country or Country o				
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Magar Ma Magar Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma	27 is n r treun		19a. Informant's Name/Relationship Lucille Rigby	sister											s, Zip Code)	
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DIVISION OF VITAL MECOLOGY, F.O. DOX 00/00, for the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 34 hours after death.	within 23, four since location.  The Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1  Live birth 4 Pregnant at 9 Unknown	2 Feta	I death 3	]Ectopic   ] Other (s	pregnancy							•	Year
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The law requir	cate has bee , page 2 shou	Completed	0								24a. Was a autop perfor 1 ☐ Yes	sy med?	dea	or to com ath?	ipletion of c	available cause of
VIIAI siclen:	certifi	o Be	25. Was case referred to medical examiner?	Hospital:				Othe	r /		(Check only or					
g Phy	er this eral di	<del> </del>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpatien 28b. Time of		OA 28c. Injury Work	4 (4/1/10)						)	
ending	or: Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	19a1)	Injury	М		res 2□1	No						
tel or Att	within 24 fours area reads.  To the Funerel Director: After this completely filled in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		iry - At ho : (Specif	ome, farm, stre	eet, facto	ry, office		2	28f. Location (S City or Tow	treet a n, Sta	ind Number (e)	or Rural	Route Num	nber,
e Hospi	• Funer	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best ominer: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurre estigatio	d at the tim	ie, date and pinion, deat	d place, a h occurre	and due to the co	ause(	s) and mann nd place, and	er as sta d due to	ited. the cause(s	s)
To th	To th comp	Me	29b. Signature and title of certifier				29	c. License	number		2	29d. D	ate signed (	Month, D	ey, Year)	
			Stahns	m				110	059	92	3	4	119/	ry		
			30. Name and address of person who	hn Son	eath (Item	23a) (Type,	Print)	10.	St. (	Zin	bride	2/	MO			
	Sta		31. Date filed (Month, Day, Yar) 2.	0 2004 Regis	r's Signa	iture 1	1	elle »	/			, -	<del>-</del>			
	Registr	ar	,,,,,,, N		PEPIL.	155	150									

unpend item#23a,27,PER ME,C831,5/13/0/eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			partment of Health and Me ertificate of Death		giene Reg. No 2004	14641
Physicia	n	1. Decedent's Name (First, Middle, Last)  Arden C. Prather		2. Date of De Month April	Day Year 18 2004	3. Time of Death 10:11 P M
/Medica Examine		4a. Facility Name (If not institution, give street and number)  Civista Medical Center	4b. City, Town, or Location of Death  La Plata		4c. County of Death Charles	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda. 212 76 2096 1 x M 2 □ F 43 Yrs.	Months Days Hours Min.	8. Date of Bir (Month, Da [uly 17	av Year) Cou	place (State or Foreign intry) land
the Maryland 28e-f show		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or           MD         St. Charles         Waldorf	Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
n the N	irect	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	
ath with	ra D	823 Roxbury Court	20602		United State	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23s or 28e-f show any injury or other traumatic event, the Modical Extrinite fourth and once.	by Fur	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No II Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R     □ Yes 2 No Specify:	orly Yes or No lican, etc.)		
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours alt partment of Health and Mental Hygiene. portant: if item 27 is marked other then "natural", or y injury or other traumatic event, the Modical Experiene.	Be Completed	(Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of workin DO NOT use retired)		16b. Kind of Business/Ir	ndustry
d 21 filed wi ther th int, the	S	12th 4years Cust 17. Father's Name (First, Middle, Last)	omer Care Administr		Private  , Maiden Sumame)	
land	To Be	Alfred Prather	Gloria	Maddux	ζ	
Aary 2 shou and N ie mai rauma			iling Address (Street and Number or Rural	Route Numb	er, City or Town, State, Zi	p Code)
1 and 1 health lem 27 ther to	8	20a Method of Disposition 20b Place of Dis	Roxbury Ct. Waldor position (Name of ematory or other place)	f, MD	20602 20c. Location - City or T	own, State
Pages nent of int: if ii		1 → Burial 2 ☐ Cremation 3 ☐ Hemoval from State  4 ☐ Donation 5 ☐ Other (Specify)  Maddux	Cemetery 04/24		Kenbridge,	
Balti permit. Departi importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Joh 3015 12th St., NE			al Home 0017
876( ate be hysicia the bu	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (piscase or injury that initiated events resulting in death) Last  Lypertersive Cardioc Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):	zascular Disease			Interval Between Onset and Death
of Vital Records, P.O. Box 68 Physicien: The law requires that the death certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Medical		B □Ectopic pregnancy S □ Other (specify)		23d. Date of deliv Month	very Day Year
	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use contribute to Yes 2 No 3 □ Pro	the cause of death?
Division of Vital Records, to Attending Physician: The law requires tafter death.  Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Completed			24a. Was auto perfo	s an 24b. Were aut prior to comed? death?	opsy findings available ompletion of cause of 2 No
f Vital F ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  X Yes 2 □ No  Hospital: 1 □ Inpatient 2 X ER/Outpat	26. Place of Death			7.1
Vision of Attending Physic death.  sector: After this by the funeral did	tion: To	1	of 28c. Injury at 2		idence 6 □Other (Speci how injury occurred	ity)
Division Attendions after death ineral Director: Aftiled in by the filled	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office		(Street and Number or Rui wn, State)	ral Route Number,
Hospi 4 hou Funer ely fiil	edical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the d at the time,	cause(s) and manner as , date and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of Cartifier	29c. License number		29d. Date signed (Month	
0		30. Name and address of person who completed cluss of death (Item 23a) (Type	O.C.M.E.  111 Penn Street, B	al+imo	April 19, 2	
Stat Registra		31. Date filed (Month, Day, Year) APR 2 2 2004		штілію	re, raryrdik	# 717AT

State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:10 A- M roole Damuel 12,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sinar Hospital Baltimore 01 5. Social Security Number 213-30-3450 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth . (Month. Day, Year) Birthplace (State or Foreign Country) **Funeral** 60 t Months 1**Ø**M 2□F Georgia Director JUN. 12,1936 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County other treumatic event, the Mudical Examiner aust be notified at 1 Yes 2 □ No Completed by Funeral Director MD Ballimore Pattent Known As: Samuel Poole 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 12 1514 or Items 23a . Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: Black 3 ☐ Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Improvence 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be Yo ole, Salee awrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Heights HVE. Balto, MD21215 Rose Mary Poole (Daughter 4822 tark 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 □ Cremation 3 □ Removal from State KING Mem. Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 4/17/2004 Woodlawn, mD injury 22. Name and Address of Facility TRI-STATE 7/5/INC 21. Signature of Funeral Service Licensee 3rD St, NW, Wash, No FON, DC 20001 Parti Enter the disease, or com shock, or heart failure. List only nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** 1 days Sepses

Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner preumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HIV 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? COPD 24a. Was an certificate has autopsy performed diameter mellitus 1 ☐ Yes 2 ☐ No 20 To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, examiner? Hospital: 1 Impatient Other: 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) erel Director: After th filled in by the funeral 27. Manner of De 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Certification; 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel f 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 12, 2004 REG-000 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shawna Escoban , MIN 31. Date filed (Month, Day, Year)
APR 1 6 2004 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 9, 2004 10:45 AM GARLAND PAYLOR 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 18, 1938 9. Birthplace (State or Foreign Country) ROXDOTO, N.C. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 2 M 2 ☐ F Months 66 238-56-4127 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Y∏ Yes 2 □ No Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3558 Warden Street, N.W.

Mantal Status

VE Never Married 2□ Married

12. Was Decedent Ever in U,S. Armed Forces?

1 □ Yes Z D No

If Yes, Give 20010 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Bus Drive D.C. Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Luvinear Hicks Lloyd Paylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9818 Bridleridge Court Vienna, Va. 22181 Trortino A. Bingham/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 4/14/04 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Northern Virginia Crematory Arlington, Va. 21. Signature of Funered 22. Name and Address of Facility
Frazier's Funeral Home, Inc. 389 R.I. Ave., N.W. Wash., DC 20001 Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ie cause on each tine. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work?

1 Yes 2 No

7600 Carroll Avenue

Takoma Park, Maryland

29c. License number

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

**Funeral** 

Director

Examiner ettending physician and I for use as the bunal-transit cate has been signed by the e pege 2 should be detached within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.

or Attending Physician: The law requiras that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/Medical ģ Be Completed

Medical

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Certification: To

To the To To The To The I 3

**DHMH 16 Rev 6/95** 

Registrar

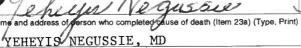
31. Dete filed (Month, Day, Year) APR 1 6 2004

29b. Signature and title of certifier

ess of

5 Pending investigation

6 Could not be determined



82. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

**ORIGINAL** 

Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

20912

28f. Location (Street and Number or Rural Route Number, City or Town, State)

		Pleas	<b>se Type or</b> State o		d / Depa	artment	of He	ealth a		l <b>Copies</b> lental Hyg		_	1161	1
		= State Registrar			Cei	tificate	of E	Death		R	leg. No.	Z 11 11 11 11 11 11 11 11 11 11 11 11 11	1464	4
Physicia	_	Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	Day		3. Time of Death	
/Medica	1	Dorothy M. L.  4a. Facility Name (If not institution)		mha rì		4h Cihr	Out of	Location of	of Doath	04	13	2004 County of Death	11:10a	101
Examine	r	Holy Cross HOs		mo <del>o</del> n)				Spri				iontgome		
uneral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under		8. Date of Birth (Month, Day			place (State or Fore intry)	ign
tor		579-24-7025	1□M 2□ <b>x</b> F	80	Yrs.	WOTHIS	Days	110013		04 01	192		h Carolin	
A 11		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limi	ts
fled	Ö	D. C.		W	ashing	ton							1 ☑ Yes 2 ☐ N	No
a la la la la la la la la la la la la la	Director	10e. Street and Number			**********	10f. Zip	Code			1	10g. Citiz	zen of What Cou	intry?	
Tunt	La	2911 South Dak			2 10	200			=== 2 / C ===	- Was as Na	US	A 14. Race - Amer	ican Indian	
	Funeral	<ol> <li>Marital Status</li> <li>Never Married 2 ☐ Married</li> </ol>	Armed Fo		.5.	If Yes, spec	fy Cubar	n, Mexican	n, Puerto	ecify Yes or No- Rican, etc.)		Bfack, White		
T T	þ	3 Widowed 4 □ Divorced	If Yes, Gir Year or D	ve		1□Yes 2	X No	Specify:				Specify: Bla	ck	
deal	Completed	15. Decedent (Specify only highes			16a. Dece	dent's Usua kind of wor DO NOT us	f Occupa k done d	ition <i>uring</i> most	t of worki	ing	16b, Kir	nd of Business/I	ndustry	
a Ma	du	Elementary/Secondary (0-12)	Colfege (								U	.S. Gov	ernment	
. (		17. Father's Name (First, Middle,	Last) 2 yr:	S	Con	nputei				(First, Middle,				
ic e	To Be	Laddie Mills						Dor	othy	Langle	У			
amme		19a. Informant's Name/Relations	hip (Type, Print)			•						Town, State, Zi		í
her tr		Rita Philson-Sl	kalski Dau		_ 2911 Place of Dispo			a Ave		The state of the s		on, D.C		_
or of		1 Daurial 2 Cremation		State	cemetery, cre	matory or or	her place	1						
Important: If item 27 is marked other than "naturel", or Items 23s or 28e-f show any injury or other traumatic event, the Medical Examiner must be rediffied at once.	1	<ul><li>4 □ Donation 5 □ Other (S<sub>i</sub></li><li>21. Signature of Funeral Service</li></ul>		L:	incoln 22				4-20 Mar			land, M eral Ho		_
eny ir		De May	shall									D.C. 2		
34		23a. Parti. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat	h. Do not en	er the mode	of dying	g, such as	cardiac c	or respiratory arr	rest,		Approximate Interval Between	
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	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ti Organ (oras a conseq		ure								
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urial-ti		resulting in death) Last	Due to	(or as a conseq	ruence of):									
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attending physics for use as the l	n/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		7					2	23d. Date of deli-	very	
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d by the	Physician/Medic	9 Unknown Part II. Other significant condition			tulting in the	ndoch den -	NIES CO	n in Dad		23a Did to	hacco ::	se contribute to	the cause of death?	
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should	etec									24a. Was a			opsy findings availal	
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		27. Manner of Death 1 ■ Natural 5 □ Pendir	'9'	of Injury oth, Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe h	iow injun	y occurred		
the f	icat	2 ☐ Accident investigned investigation investigned investigation investig	gation not be	e of Injury - At h	ome, farm. st	M reet, factors		Yes 2 🗆		28f. Location /S	Street and	d Number or Ru	ral Route Number,	
d in b	Certification:	4 Homicide determ	build	ting, etc. (Speci	(y)		, 0.1100			City or Tow				
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1		30. Name and address of person Ahmed Nawaz M		se of death (Ite			shur	о м	D. 20	0883				
Stat	te	31, Date filed (Month, Day, Year)	32.1	Registrar's Sign.	ature /	• ·	SPUL	E PIL	U					
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ORIGINAL

UNKNOWN	04-13	6	State of Maryland / Department of Health and N	=	_	
		•	- State 4-29-04 Registrarymend #5. 7.& 8.Per Fam. PGC cr Certificate of Death		eg. No. 2004	14645
- Es	K 2 *		1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month		3. Time of Death
	Physicia /Medic		Lonniel Peterson	APRIL	19, 2004	0545 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)  501 Moat Way  4b. City, Town, or Location of Death FORT WASHINGTON		4c. County of Dea PRINCE (	
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 43 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, July 3	Year 1960 9. Bir Co	thplace (State or Foreign ountry) Sh. D.C.
<u></u>	*		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryla	a-f sho	ctor	Md. P.G. Oxon Hill			1 <b>N</b> es 2 No
with the	ral', or Items 23a or 28a-f show Examiner must be notified at	Funeral Director	10e. Street and Number 6255 Oxon Hill Road 10f. Zip Code 20745	10	0g. Citizen of What Co	ountry?
r deat	ems 2	iner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
036 urs afte	al', or lt Examin	þ	1 Never Married 2 Married 1√2 Yes 2 No army 1. Yes, Give 1 Yes, Give Year or Dates:		Blac! Specify:	k
5-0	"natur dissili	eted	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired)  [Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business Automot	
21215-0036	giene. rrthan "natu the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Car Detailer		Aucomoc	1.46
and b	ental Hyg ked othe fc event,	To Be C	17. Father's Name (First, Middle, Last) Roger Dowdell 18. Mother's Name Cathe	e (First, Middle, M Prine Pe	Maiden Sumame) eterson	
Maryland d 2 should be file	Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmet must be notified at once.	-	19a. Informant's Name/Relationship (Type, Print)  Catherine Peterson-Mother  19b. Mailing Address (Street and Number or Rur 6255 Oxon Hill Roa	ral Route Number, ad Oxon	City or Town, State, Hill Md	Zip Code)apt202 .20745
lore,	If item 2		1 Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place)	0.4	20c. Location - City or Washingto	
Baltimore,	apartmer aportant by injury		21. Signatur of Funeral Service Licensee  Robinson Funeral			
ш 8	66 2 60	-	23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
1/6	nysician :		Immediate Cause (Final disease or condition			Interval Between Onset and Death
	/Medical xaminer		resulting in death)  Due to (or as a consequence of):			
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3760,	hysicier the buri	cal	d			
omitic	attending phy	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery
P.O. Box 68	the atter	Physician/M	23b. Was decedent pregnant in the past 12 months?  1		Month	Day Year
<b>S</b> . P.	been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
COTC	speens	ompleted		24a. Was ar	n 24b. Were at	utopsy findings available
Division of Vital Records,	his certificate has b	Comp		autops perform 1 Yes 2	ned? death? 2 □ No 1 □ Yes	completion of cause of
Vite	certifi	o Be	examiner?	th (Check only one	e) ence <b>6XX</b> Other (Spe	AII COUNT
n of	ter this	-	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury United States of Injury Unit	28d. Describe ho	w injury occurred	4
SiOn	tor: Af	catlo	2 Accident investigation investigation of 4-19-04 and 5-41A M 1 Yes 2 ANO	Subjer	reet and Number or R.	viral Bouta Number
Divi	s after of Direction by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town	1, State) 50 1 M	out Way
H G	To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, considerable of the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the ca rred at the time, da	tuse(s) and manner as ate and place, and dur	s stated. e to the cause(s)
40	withir To th	Me	29b. Signature and title of certifier  O.C.M.E	25	9d. Date signed (Mont APRIL 19	th, Day, Year) 0, 2004
OR, (	3)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LING LI. MID 111 Penn Street, Baltimo	ore, Marv	land 21201	<u>.</u>
	Sta		31. Date filed (Month, Day, Year)  2. Registrar's Signature	1		
0	Registr	ar	APR 2 2 2004 Bloken & Species			

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  The Manual Hygiene and Health and Mental Hygiene and the market enclined at the market of the market enclined at the market encline	4a. Face 5. Social 5. Social 5. Social 10a. St. D 110e. St. 11. Mar 1	8-66-6371 lesidence of Decedent site 10b. County C eet and Number 1739 First S tal Status Never Married 2 Married Widowed 4 Married (Specify only highest g. entary/Secondary (0-12) 12th er's Name (First, Middle, Las	St., N.W.  12. Was Decedent E. Amed Forces? 13. Yes 2 \( \) No Wester or Dates:  Education rade completed)  College (1-4or 5+)	16a. Dec	Was Dec If Yes edent's Us e kind of w	Sider 1 Year s Days  ashing	Location of Deat Location of Deat Location of Deat Location of Deat Location of Deat In Under 24 Hrs Hours Min.  Ston  20001  Spanic Origin? (So., Mexican, Puerl	B. Date of Bir (Month, Da Oct. 2	4c. County of Mark Year)  10g. Cilizen of Will Unite  14. Race	ontgomery  9. Birthplace (State or F Country) Wash., DC
Learning the maryland all, or iteme 23a or 28a-f show all, or iteme 23a or 28a-f show all the modified at the	4a. Face  5. Social  5. Total  10a. St.  11. Mar  11. Mar  17. Fath  19a. Inn  No.  20a. Me	Holy Cross Holls I Security Number 6.  8-66-6371  esidence of Decedent the 10b. County Companies 10b. County Companies 10b. County Companies 10b. County Companies 10b. County Companies 10b. County Companies 10b. County highest greatery/Secondary (0-12) 12th 10b. Companies Norman T. Companies Name (First, Middle, Las Norman T. Companies Name/Relationship	Sex 12 7. Age 7. Age 12 M 2 F 7. Age 12 M 2 F 7. Age 12. Was Decedent E Armed Forces? 12 Yes, Give Year or Dates:  Education rade completed)  College (1-4or 5+	755 Yrs.  10c. City, Town or L  ver in U.S. 13	Was Dec If Yes edent's Us e kind of w	Sider 1 Year s Days  ashing Zip Code	Iver Spi If Under 24 Hrs Hours Min.	B. Date of Bir (Month, Da Oct. 2	Month  3/2 (Year)  5, 1948  10g. Cilizen of Will  Unite  14. Race	ontgomery  9. Birthplace (State or F Country) Wash., DC  10d. Inside City 1 XYes 2 hat Country? ed States - American Indian,
Live riter death with the Maryland at yor itame 23 or 28a-f show at Examinat must be notified at by Funeral Director	57 Usual F 10a. St  11. Mar 1	Security Number  8-66-6371  lesidence of Decedent  Itelesidence of Decedent  In the security of Security of Security of Security of Security (0-12)  I 2th  I Shame (First, Middle, Las Norman T. Cormant's Name/Relationship	St., N.W.  12. Was Decedent Ender Armed Forces? 1X Yes, Give Year or Dates: Education rade completed)  College (1-4or 5+	755 Yrs.  10c. City, Town or L  ver in U.S. 13	Was Dec If Yes, sp	der 1 Year s Days  ashing Zip Code  Redent of Hisecrity Cubar	If Under 24 Hrs Hours Min.  Ston  20001	8. Date of Bir (Month, Da Oct. 2	10g. Cilizen of Will Unite	9. Birthplace (State or F Country) Wash., DC  10d. Inside City 1
Live riter death with the Maryland at yor itame 23 or 28a-f show at Examinat must be notified at by Funeral Director	57 Usual F 10a. St  11. Mar 1	8-66-6371  lesidence of Decedent  ste 10b. County  C  eet and Number  1739 First S  tal Status  Never Married 2 Married  (Widowed 4-10-10-10-10-10-10-10-10-10-10-10-10-10-	St., N.W.  12. Was Decedent Endemoder Forces? 1X Yes, Give Year or Dates: Education rade completed)  College (1-4or 5+	755 Yrs.  10c. City, Town or L  ver in U.S. 13	Was Dec If Yes, sp	ashing Zip Code Sedent of His	Hours Min.	Oct. 2	10g. Cilizen of Will Unite 14. Race	Wash., DC  10d. Inside City 1 XYes 2 hat Country? ed States - American Indian,
ages i and 2 should be filed within 72 hours after death with the Maryland of the filed hand Mental Hygiene.  If if the AT is marked other then "natural", or itame 23s or 28s-f show y or other treumatic event, the Medical Examinar mast be notified at To Order to the Completed by Funeral Director	10a. St.  D 10e. St.  11. Mar  1	tele 10b. County C eet and Number 1739 First S tal Status Never Married 2 Married Widowed 4 More red (Specify only highest giventary/Secondary (0-12) 12th er's Name (First, Middle, Las Norman T.	St., N.W.  12. Was Decedent Ender Armed Forces? 1XIVes 2 In No. If Yes, Give Year or Dates:  Education rade completed)  College (1-4or 5+	ver in U.S. 13	Was Dec If Yes, sp	Zip Code	20001	pecify Yes or No	Unite	1 Tayes 2 hat Country? ed States - American Indian,
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ages I and 2 should a control of the alth and Mont. It. If I them 27 is marked y or other treumatic a	19a. Int No.	ormant's Name/Relationship	. Queen, Sr.						Maiden Sumame,	
ages I and 2 should not of Health and 27 is my for other treums	19a. Ini Ne 20a. Me							Barbara	E. Holme	es
ages i a int of He t: If item y or othe	1 [			19b. Mail	ling Addres	ss (Street a	nd Number or Ru er Pl.,	ral Route Numbe	er, City or Town, Si	tate, Zip Code) 2301
ا ا ا ا ا ا ا ا ا ا ا ا ا ا ا ا ا ا ا		thod of Disposition  Burial 2X1 Cremation 3 [		20b. Place of Disp cemetery, cre	osition (Na	ame of		Date	20c. Location - C	ity or Town, State
5 5 5	'4 □ Donation 5 □ Other (Specify)     Lee's Crematory     4/18/2004     Clin       21. Signature of Funeral Service Licensee     22. Name and Address of Facility     Stewart Funeral									on, MD
Departr Importa eny inje	21. Sign	ature of Funerat Service Lice	onsee A T		2. Name a	and Address	of Facility S	tewart ]		lome
The state of	23a. Pa	fil Enter the disease, or conock, or heart failure. List only	nplications that caused the	ne death. Do not en						Approximate
hysician	Immedi	ate Cause (Final or condition		erebral H	Iamar	rhago				Onset and Dea
/Medical		g in death)		consequence of):	iciioi i	Inage				Days
xaminer	Sequen	ially list conditions.	b. Hypert	ension						Years
if ne	cause.	ially list conditions, ading to immediate Enter Underlying		consequence of):						
physician and strength of the burial-transit	that initi resulting	Disease or injury ated events in death) Last		Insuffici	ency					Days
g phy as the			d							
this cartificate has been signed by the attending phral director, page 2 should be detached for use as the To Be Completed by Physician/Medi	23b. Wa	LE: s decedent pregnan1 he past 12 months? Yes 2 \[ \subseteq No \] Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)							of delivery Day Year
ad by detac	Part II. C	ther significant conditions	contributing to death but	not resulting in the u	and orbital		in Boat	02- 0:44-		
been signed be should be detailed by PI				not resulting in the ti	indenying (	cause given	in Parti.		es 2 No 3	ute to the cause of death
cate has been s page 2 should								24a. Was a		re autopsy findings avai
cate pag								perfor	med? dea	
ector, pag	exan	case referred to medical inner?	Hospital:				26. Place of Deat	h (Check only or	1e)	
r this certificated fra director, I	27 Man	res 2 No	1 LA Inpatient	2 ER/Outpatier			4 Li Nursing Ho		ence 6 Other (	(Specify)
death. tor: After thi the funeral of	1 🗖	latural 5 ☐ Pending Accident investigatio		'ear) 28b. Time of Injury	M	28c. Injury a Work? 1 ☐ Ye	at es 2 □No	28d. Describe ho	ow injury occurred	
rs after death. al Director: After led in by the funera Certification:		Suicide 6 Could not be determined		- At home, farm, str 'Specify)	eet, factor	y, office		28f. Location (Si City or Town	treet and Number on, State)	or Rural Route Number,
Funer Funer ely fill	29a. Cer (Ch	tifier 1 CertifyIng Ph sck only 2 Medical Example	and due to the ca	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)					
within 2 To the complet	29b. Sig	nature and title of certifier			290	c. License r	number	2	9d. Date signed (A	Aonth, Day, Year)
	•	D. Vilwama	dilya le	ddig M	D	D43	464			8- 2004
61	30. Nam	and address of person who	completed cause of deat	h (Item 23a) (Tyne	Print)				17 1= 20 1= 0	5

	•	For State of Registrar			ertificate of			Reg. No.	004	1464
Dhysisias	_	Decedent's Name (First, Middle, Last)			(3)		2. Date of De Month	ath Day	Year i	3. Time of Death
Physiciar /Medica	al .	Themas			0.00	een	April	18	POOS	140 A M
Examine		4a. Facility Name (If not institution, give street and num	ber)	i	0 11.	or Location of Dea	ath	4c. Cour	nty of Death	
		The Johns Hopkins 1.	7. Age (In yrs.	last hirthda		If Under 24 Hr	s. 8. Date of Bir	th	9 Right	lace (State or Foreign
eral ctor		5. Social Security Number 6. Sex 1 M 2 □ F		51 Yrs.	Months Days			Year) 1943	Mar	yland
tor		Usual Residence of Decedent		7.1					1	
		10a. State 10b. County	10c. Cit	ty, Town or	Location				1	Od. Inside City Limits
To De Committee by English Britain Britain Britain	to	Maryland   Prince George	Upp	per Ma	r1boro					1. Yes 2 No
1 2	olre.	10e. Street and Number			10f. Zip Code			10g. Citizen		•
3	al	11812 Fairgreen Lane			20772				ed Sta	
har France	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Widowed 4 □ Divorced  12. Was Dece Armed For 1 ☑ Yes, Giv Year or Day  13. Widowed 4 □ Divorced	ces? 2 ∐ No e	I.S. 13	3. Was Decedent of ff Yes, specify Cul 1 ☐ Yes 2 ☑ No		(Specify Yes or No arto Rican, etc.)	E	lace - Americ lack, White, cify: Bla	etc.
3	eted	15. Decedent's Education (Specify only highest grade completed)		(Giv	edent's Usual Occu ve kind of work done	during most of w	rorking	16b. Kind of	Business/Ind	dustry
1	du	Elementary/Secondary (0-12) College (1	-4or 5+)	life	. DO NOT use retire	∍d)		Corror	nmon+	
	S	12 5		Admir	nistrator		ame (First, Middle		nment	
ó	Be	17. Father's Name (First, Middle, Last) Thomas W. Queen					H. Taylo		alliej	
F	ဥ			10b Ma	iling Address (Stree				um State Zin	Code
		19a. Informant's Name/Relationship (Type, Print) Brenda A. Queen/Spouse		1181	l2 Fairgr	een Lane	, Upper N	lar1bor	o, MD	20772
į		20a. Method of Disposition	20b. F	Place of Dis	position (Name of rematory or other pla	. 1	Date	20c. Locatio	n - City or To	own, State
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 3 4 ☐ Donation 5 ☐ Other (Specify)	State		rematory or other pi Memorial		24/04	Suit1a	nd, M	)
once.	3	21. Signature of Funeral Service Licenses	7		22 Name and Addr	ess of Facility				
once		When the	le	1	22 Name and Addr Alexander 5538 Marl	S. Pope boro Pik	Funeral e. Foresi	Home	MD 2	20747
		23a. Part1. Enter the disease, or complications that control shock, or heart failure. List only one cause on e	aused the deal	th. Do not e	enter the mode of dy	ing, such as card	ac or respiratory a	rrest,	TID 2	Approximate Interval Between
张-	}	Immediate Cause (Final	ach line.	2	~ 1		* . /			Onset and Death
an al		disease or condition resulting in death)	or as a consec	quence of):		-rijaa	· <del>Y · · · · · ·</del>			01-24/5
ner		Tho	raco	~ a	blomin	alaort	ic an	eury	Sm	2 month
1	ner	Sequentially list conditions, if any, leading to immediate  Due to (	or as a consec	quence of):						
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
ı	EX	resulting in death) Last Due to (	or as a consec	quence of):						
	lcal	d								
	Physician/Med	IF FEMALE: 23c. If yes, out	come of pregn	ancy				024	Date of delive	
-	lan	in the past 12 months?	inth 2 ☐ Feta ant at time of o	al death	3 □Ectopic pregnan 5 □ Other (specify)	су			Month	Day Year
	yslo	1 Yes 2 No 9 Unknown								
i		Part L Other significant conditions contributing to de	ath but not res	sulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use c	ontribute to th	ne cause of death?
:	d by	Preizmonia					1 🗆	Yes 2	3 ☐ Prob	ably 4 Unknown
	Completed	8 mailema					24a. Was	an 24	b. Were auto	psy findings available
1	dmo	CTPY						ormed?	death?	
	မ င်	25. Was case referred to medical				26 Place of C	1 ☐ Yes leath (Check only		1 🗆 Yes	2□ No
1	0 0	examiner?	npatient 2	BR/Outpat	ient 3□ DDA O	thor	Home 5 ☐ Res		Other (Specifi	iv)
	$\vdash$	27. Manner of Death 28a. Date	of Injury	28b. Time	of 28c. Inj		28d. Describe			,,
	ilo	Natural 5 ☐ Pending (Monit	h, Day Year)	Injun		ork? ☐Yes 2 ☐ No				
	ifice	3 ☐ Suicide 6 ☐ Could not be 28e. Pface	of Injury - At h	nome, farm,	street, factory, office	3	28f. Location (	Street and Nu wn, State)	mber or Rura	I Route Number,
	Certification;	4   Hornicide Buildi	ig, etc. ( <i>Speci</i>	ily)			Only of 10	mi, State)		
		29a. Certifier Certifying Physician: To the								
		(Check only 2 Medical Examiner: On the bone) and man	ner stated.	ation and/or			curred at the time,			
	edic	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date sig	ned (Month,	Day, Year)
.	Medical	Sun a cont			Rt	=S- C	000	4/1	8/200	04
1	Medic			m 23a) (Tun	o Drint)					
	Medic	30. Name and address of person who completed caus	e of death (Ite	#11 23a) (1 <b>y</b> L	oe, Finiti	1 /		10	6	11
	Medio	Thomas Keane MD 7	he Jo	ohns f	toplans	Hospite	1 600 N	Wolfe	24 B	2 MOHOD ZA
Stat	ite	Thomas Keane MO 7 31. Date filed (Month, Day, Year) 32. F	e of death (Ite	ohns f	1.1.	Hospita	1 600 N	Wolfe	S4 B	SaltoMD 21
Registra	ite ar	Thomas Keane MD 7	he Jo	ohns f	1.1.	Hospite	1 600 N	Wolfe	S4 B	altoMD2
Stat Registra	ite ar	Thomas Keane MO 7 31. Date filed (Month, Day, Year) 32. F	he Jo	ohns f	toplans	Hospite	1 600 N	Wolfe	S4 B	BaltoMDZ

ORIGINAL

		1	For State Registrar	State of I	Marylan	d / Depa	rtment	of H	ealth ar Death	nd M		g. No.	/ 13 13 1	
	Physicia /Medic	an ai	1. Decedent's Name (First, Middl Boris Rabkin								2. Date of Death Month 4-20-04	Day	Year	3. Time of Death 4:00 A. M
	Examin	er	4a. Facility Name (If not institution Suburban Hospit	al		last birthday)	4b. City,  Beth  If Under	esda	Location of		8. Date of Birth		ntgome	
	Funeral Director		5. Social Security Number  054-14-8568  Usual Residence of Decedent	6. Sex 7. 1 ★ 2 ☐ F	84 84		Months	Days	Hours	Min.	(Month, Day, 6-3-19]	L9	- N	Y
	a-f ahow	ctor	10a. State         10b. County           MD         Montg	omery		y, Town or Lo lver S <sub>l</sub>								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
:	23a or 28	ral Director	10e. Street and Number 315 Scott Dr.					0904				U.	S.A.	
030	filed within 72 hours after death with the Maryland Hygiene 1 ther than "naturel", or Items 23e or 28e-f ahow ent, the Midical Examinal must be modified at	by Funeral	11. Marital Status  1 Never Married 2 X Mar  3 Widowed 4 Divorced	If Yes, Give	es? □ No T√T		Was Deced t Yes, spec 1 ☐ Yes 2			in? (Spe Puerto I	ecify Yes or No- Rican, etc.)		I. Hace - Am Black, Whi	erican tndian, te, etc.  White
0-CLZ	within 72 ho ene. than "natur he Modical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)  Cotlege (1-4	or 5+)	16a. Deced (Give life.	kind of wor DO NOT us	l Occupa k done d e retired)	ition lu <i>ring</i> most ( )	of workii	ng	16b. Kind	of Business	:/Industry
Maryland 21215-0036	uld be filed Mental Hygid Irked other Itic event, I	To Be Co	17. Father's Name (First, Middle, Isadore RAbki	Last)		ritys	CLAI				(First, Middle, M Covner			
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If time 77 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examinat must be neditive at annes.		19a. Informant's Name/Relations  Dorothy Sislen  20a. Method of Disposition  1 ∰ Burial 2 □ Cremation  4 □ Donation 5 □ Other (3	Rabkin - W	20b. F		cott esition (Nam matory or o	Dr. ne of ther place	Silve	r S		D 20 20c. Loca	904	r Town, State
Baltii	permit. F Departme importer any injur		21. Signature of Funeral Service	Licensee And	uler	1	2. Name an	d Addres	Hampsl	hire	nes-Rina Ave. S:	aldi ilve	Funer	
760,	Physician be executed attending physician and attending physician and for use as the burial-transit	Ilcal Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis temediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		PLE uence of):		YE	LON	1A	LURE	331,		Approximate Interval Between Onset and Death	
.O. Box 68	The law requires that the death certifica tie has been signed by the attending phoage 2 should be delached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2∏Feta ntattime ofd	ildeath 3	Ectopic pr Other (sp					23	8d. Date of de Month	blivery Day Year
rds, P.	requires that t been signed by should be detac	þ	Part II. Other significant condit	ons contributing to dea	th but not res	ulting in the u	nderlying c	ause give	en in Part I,		23e. Did tob	- 1	/	to the cause of death? Probably 4 ☐Unknown
Il Records,		Completed						_			24a. Was an autops perform	y ned?	24b. Were a prior to death?	
on of Vital	ding Physician: Th.  After this certificate funeral director, pag	lon: To Be	25. Was case referred to medic examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pend	Hospital: 1 Ving		ER/Outpaties 28b. Time of tnjury		8c. Injury Work	er: 4 Nurs	sing Ho	me 5 Reside Reside 28d. Describe ho	ence 6		ecify)
Division	al or Attending s after death. Il Director: After id in by the funer	Certification:	3 Suicide 6 Could	not be 28e. Place o	f Injury - At h g, etc. <i>(Speci</i> l	ome, tarm, st					28t. Location (St. City or Town		Number or F	Rural Route Number,
	To the Hospital or Attending I within 24 hours after death.  To he Funeral Director: Atter completely filled in by the funer	Medical (	(Check only 2 Medica one)	ng Physician: To the b I Examiner: On the bas and manne	is of examina		vestigation	, in my of			ed at the time, da	ate and p	place, and du	
)	10	2	29b. Signature and title of certification of certification of the certif	lyman	of death (lea	7-7)	Drint)	D -	27			41	12=/=	
2	St	ate	30. Name and ad ress of perso AUAWA 31. Date tiled (Month, Day, Yea APR 2	605WAM		) -	119	Roca	× VILLE	E	PILE	R	allui (	cit.
6	Regist		APR 2 3	2004	رصمعها	19	Spo	aks	/					

BORIS O400 4/20104

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** APRIL 19, 2004 01:20P M PAVEL L. RAPPOPORT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 RUSSIA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 11XM 2□ F 87 APRIL 6. Director 212-21-7851 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County r than "natural", or items 23s or 28s-f show the Medical Exercities must be notified at 1 X Yes 2 ☐ No **Funeral Director** MONTGOMERY MARYLAND ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 249 ROLLINS AVE. #102 20852 UNITED STATES OF AMERICA death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z.No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Healin and Mentel Hygene. Department of Healin and Mentel Hygene. Innocrant: If item 27 is marked other than "natural, or ite any injury or other traumatic event, the Medical Externites any injury or other traumatic event, the Medical Externites. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🂢 No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ CHEMIST RUSSIAN GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEV RAPPOPORT MARIA KLEMPNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARINA P. RAPPOPORT - DAUGHTER 7401 WESTLAKE TERRACE, #907 BETHESDA, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 04/22/04 OLNEY, MARYLAND 21. Signature of Funeral Service Licenses ANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) NEUMONI **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to influential cause. Enter Underlying Cause (Disease or injury that influentialed events resulting in death) Last Due to for as a consequence of Examiner attending physicien and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fetopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2XXNo Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No has autopsy page 2 this certificate 1 🗌 Yes 2X No Division of Vital or Attending Physicien: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3□ DOA 2 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Magner of Death Certification; After Natural 5 ☐ Pending death. 2 🗌 No investigation 1 TYes 2 Accident I hours after death unerel Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OCKVILLE MON-6121 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State 2004 22 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 400 12:28 AM **Physician** pril 2004 AUDREY E. REID /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Pr. George's Co. Doctors Community Hospital Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 XF Min. Months Days Hours Yrs. December 26, 1931 Virginia 229-36-0873 72 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylann nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itama 23a or 28a-f show ury or other traumatic event, the Moulscal Exuita accurate be notified at the content of t 1 Yes 2 No Funeral Director Virginia Fairfax Fairfax 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22031 U.S.A. 3117 Buccaneer Court, #102 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Accounting Specialist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Evelyn T. Sudduth Clifton T. Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12019 Fairway Ct., Glenn Dale, MD 20769 Margaret Mortillaro (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit Pages i Deparment of F Important: If ite any in ury or ot once. 1X Burial 2 Cremation 3 Removal from State 04/22/04 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park Signature of Funeral Service Licensee 22. Name and Address of Facility Murphy Falls Church Funeral Home 1102 W. Broad St., Falls Church, VA 22046 anne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hronic Obstructive Pulmonary **Physician** /Medical Due to (or as a consequence of): **Examiner** Due to (oras a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 No 212No 1 Tyes this certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 1 DOA 1 Yes 2 No Medical Certification; To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation To the Hospital or Attend within 24 hours after death √c the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide pelli to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DO042684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 = 351 LAUKE # 30707 75 42010 25025 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State APR 22 2004 Registrar

			For State Registrar		State of Ma	iryland / D	epa Cer	rtment of tificate o	неа f De	iith and Mi e <b>ath</b>		gien Reg. N		46	552
	Physicia	an	1. Decedent's Name  RAYMOND	(First, Middle, Las	RIPPON		-				2. Date of Dea Month April		ay Year • 2004	3. Time of 6:00	Death P M
	/Medic Examin		4a. Facility Name (If Casey Ho	not institution, give				4b. City, Town		cation of Death	-F	4	c. County of Deat	th	
	Funeral Director		5. Social Security Nu 577-09-43	6. Se 123	ax 7. Age	e (In yrs. last birth	nday) 'rs.	If Under 1 Yes Months Day	ar If	Under 24 Hrs. lours Min.	8. Date of Birt (Month, Day July 2,		0.0:-	hplace (State of buntry) nington	D.C.
	ryland how		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	or Loc	ation						10d. Inside C	•
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State of Maryland / Department of Health and Mental Hygiene

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_	1	30. Name end address of person who co	mpleted cause of deet	h (Item 23e) (Typ	e, Print)			-		
)	- 33.0 - E	Mary Callsen, M.D	., 6000 Ex	ecutive	Blvd., #30	00 Rocky	ville, MI	20852		
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 14654 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 1921 Enore 7004 4b. City, Town, or Location of Death /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner mont 7504 No Takoma 419 Omers If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State of Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Days Months Hours 1 □ M 2 🔼 F Yrs. Director 60 064-34-0694 N.T Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits show r than "netural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7504 Holly Ave. 20912 U.S.A.
14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 1 Married ☐ Yes 2 ☑ No Yes. Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Administer Natn'l Ed. Assn. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental H Gus Naimer Beatrice Stern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a Important: If item 27 Is any Injury or other trac 7504 Holly Ave. Takoma Park, MD 20912 Lawrence M. Robinson - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 2 Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Gardens 4-21-04 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines—Rinaldi F. H. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ASCVO Examiner Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown δ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate has director, page 2 20 No 1 Tyes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) aminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ဂ္ 1 Yes 2 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1. Natural 2 ☐ Accident 5 Pending investigation 1 Tes 2 No Director: / 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter

To the Funeral Dire

completely filled in b Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the Dasis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the ature and title of certilier 29b 29c. License number DME C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $\bigcap_{i > j} (i > j)$ 

State Registrar

DHMH 16 Rev 6/95

31. Date filed

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MO DME

Registrar's Signature

1- For Unpend Item #2State of Maryland Dep Registra MEND#4bperME4/23/04, EMW, MCCO Ce	artment of Health and Mantal Hygiene 2004 rifficate of Death	14656
1 Decedent's Name (First Middle Leat)	2 Date of Dooth	C. Time of Death

Physician   Pedage   1. Decedent's Name
Physician /Medical Examiner  4a. Facility Name 17009  Funeral Director  Usual Basidence
Funeral Director 5. Social Security 218–92-3
Sustain Part   Constitution   Consti
within 72 hours after death with the Mary 100. Street and N 17009  The Mary 100. Street and N 17009  The Mary 100. Street and N 100. Stree
within 72 hours after death williams 1.29036  11. Warital Status  1 Description on pleted by Funeral Conference on the Marital Elementary (See Section 1.2)  12.0036  13. Widowed  14.0036  15. Section of the Marital Status  15. Widowed  16. Section of the Marital Status  16. Section of the Marital Status  17. Section of the Marital Status  18. Widowed  19. Section of the Marital Status  19. Section
within 72 hours after liene. The Market you let the
ompleted (Social Section 2)
To Father's Name
Mary Mary 19a. Informant's I Loanna
Baltimore, Maryland 212  Beamit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiene. Importent: If item 27 is marked other than importent: If item 27 is marked other than any injury or other treumatic event, item 2009.  To aun:
Balti Departm Importe Bond injunction of the same injunction of the

me (First, Middle, Last) Month Dav April 2004 <u>Ann Ramsey</u> 18 (If not institution, give street and number) 4b. City, Town, or Location of Death Derwood 4c. County of Death Dace Drive Deerwood Montgomery If Under 1 Year If Under 24 Hrs. Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min. Hours Months 1 □ M 2 🖼 F 3555 37 Jan. 31, 1967 Maryland of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Montgomery Rockv111e umber 10f. Zip Code 10g. Citizen of What Country? Dace Drive 20855 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: rried 2X Married Specify: White 1 ☐ Yes 2 Po Specify: 4 Divorced 15. Decedent's Education ecify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) Homemaker Own Home e (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter J. Ramsey ပ Elizabeth Ann Cassel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ioanni Kalivas/ Husband 17009 Dace Drive, Derwood, MD 20855 20b. Place of Disposition (Name of Date 20a Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) April 23, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 □ Donation 5 ☑ Other (Specify) Mausoleum Gate of Heaven Cemetery 2004 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901
Addressing Address of Facility
Approximate 21. Signature of Fyneral Service Licensee rehond Z 40/10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METHADONE INTOXICATION disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Priysician /Medical **Examiner** 

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death.

after death Director: the

within 24 hours a

To the Funerel C Fo the Hospitel

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The law requires that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital or Attending Physicien: Examiner

Completed by Physician/Medical

Be

2

Certification:

Medical

IF FEMALE

23b. Was decedent pregnant

☐Yes 2☐No

9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

3 🗍 Suicide

4 Homicide

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death 3 Ectopic pregnancy

4☐Pregnant at time of death

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

CHRONIC ALCOHOLISM

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 DUnknown 1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed? 1 Yes 2□No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Hospital: 1 ¥ Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28*a.* Date of Injury **FOUND**, Day Year) **4/18/04** 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

28b. Time of 28c. Injury at Work?  $\underline{\mathbf{A}}^{\mathbf{A}\mathbf{T}}$ FOUND 7:00 1 ☐ Yes 2 XNo 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5 Other (specify)

Other: 4 Nursing Home 5 Residence of Other (Specify) at SCHIE 28d. Describe how injury occurred

UNKNOWN Location (Street and Number of Bury Roll NUMBER City or Town, State) 17009 DACE DRIVE DEERWOOD, MARYLAND

April 19, 2004

FOUND AT HOME 29a. Certifier (Check only one)

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 29c. License number w

and manner stated

29d. Date signed (Month, Day, Year)

mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LING LI

APR 2 3 2004

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

State Registrar

32. Registrar's Signature Shour sacks! State of Maryland / Department of Health and Mental Hygiene 2 0 01.

			1 = State Registrar		Cei	rtificate of I	Death		Reg. No.	140	J
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Dea	ath
	Physici /Media		WINIFREI	м.	RAMOS			APRIL		7:00 P	М
	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of De	eath	4c. County	of Death	
			6004 89th AV	E.		NEW	CARROLL		PRI	NCE GEORGES	
	Funeral Director		578-38-6563	M XIE	n yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 h	lin. (Month, D.	rth ay, Year) 18,1924	9. Birthplece (State or Fo	reig
	pu *		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City L	imits
	e Maryla Sa-f eho	Director	MD. PRINCE GE	EORGES	SI	EAT PLEAS	ANT			1 <b>X</b> Yes 2 [	
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of		
	s 23s	ra	608 CABIN BRA		in II C   12 1		0743	(Cnosity Vac as N		J.S.A.	
	72 hours after death with the Maryland naturel', or Itams 23s or 28s-f ehow licel Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 X No	Specify:	(Specify Yes or No Lerto Rican, etc.)		ck, White, etc.	
	72 hou	ted	15. Decedent's Edu	cation		dent's Usual Occup		working	16b. Kind of B	lusiness/Industry	
	within Bne. than	Completed	(Specify only highest grade Elementary/Secondary (0·12) 12	College (1-4or 5+)	life.	MEAT WR	1)	working	SAF	FEWAY	
	Hygin other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden Sumar	ne)	
		To B	CHARLES	IBBO	)TT			FLORIST	ANNE	BRIDGES	
•	de la maria		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number or	Rural Route Numb	er, City or Town	, State, Zip Code)	
	1 and 2 Health a		ELEANOR EDWARDS	/DAUGHTER	6004		AVE., N	IEW CARRO			
	0 0 = =		20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	•	sition (Name of natory or other place CREMATO	· 1	Date 3-2004		OALE, MD.	
	Department Department Important:		21. Signature of Funeral Service License	as Mara GIZ	22 CI	Name and Addres	ss of Facility	HOME & C	REMATORI	UM.P.A.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	ACUTE RES  Due to (or as a constant)  CONGESTIVE	SPIRATORY consequence of):  VE HEART ]	FAILURE	g, such as card	diac or respiratory a	arrest,	Approximate Interval Betwee Onset and Deat 5 DAYS  2 YEARS	
,00,00	certificate be executed ding physician and ise as the burial-transit	/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a control of the contr						15 YEARS	
V. D.	certif ding se as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2   4 Pregnant at tin 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,			ite of delivery onth Day Year	
_	ires that the de signed by the a d be detached f	þ	Part II. Other significant conditions con	ntributing to death but i	not resulting in the u	nderlying cause giv	en in Part I.			tribute to the cause of death	
VII DECOIDS	The law requires that the death rate has been signed by the atter page 2 should be detached for t	Completed						24a. Was	opsy ormed?	Were autopsy findings available prior to completion of cause death?  1 Yes 2 No	lable a of
	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?	In a chall			26. Place of I	Death (Check only	one)	DAHOUPEDE	
5	Phys	lon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time of Injury	28c. Injun Wor	y at k?	g Home 5 🖸 Res 28d. Describe	idence 6 COth how injury occur	DAUGHTERS HOME rred	
DIVISION	Attender deatlecter:	Certification:	2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)  M 1 Yes 2 No  28f. Location (Street and Number City or Town, State)								
	To the Hospital or within 24 hours affer To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of a ner: On the basis of e and manner state	kamination and/or in	h occurred at the tin vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the courred at the time,	cause(s) and made, date and place,	anner as stated. and due to the cause(s)	
	To the H within 24 W To the Fq complete	Me	29b. Signature, and title of certifier	16 m		29c. Licens	e number 2 ( 88 3	3	29d. Date signe	ed (Month, Day, Year) 2104	
				mpleted cause of dea			RD., S	SUITE #31.	5, LANHA	M, MD.20706	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) APR 1 3 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL Physician ALVIN REAM 14, 2004 12:10P. <sup>™</sup> C. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 606 University Boulevard East Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ₹M 2 □ F Pennsylvania 86 March6, 1918 Director 201-01-7533 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other then "natural", or items 23a or 28a-1 show ury or gither traumatic event. It a Medical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20901 606 University Boulevard East United States Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receiving Clerk Marriott Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ream Zembower Newton ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Ream -wife 606 University Blvd., East Silver Spring, Md. 20901 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or of once. 1 Nurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 4/19/2004 Richland Cemetery Johnstown, Pennsylvania 21. Signature of Funeral Service Lice Service Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Metastatic Lung Cancer 2 months resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause lossesses are jury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. physicien Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deal
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached P.0 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, emphysema 1 X Yes 2 □ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performe 1 Yes 2X No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 XNatural 5 Pendina Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 Name and address of person who competed cause of death (Item 23a) (Type, Print) Karen L. Jerome M,D. 8700 Georgia Avenue, #400 Silver Spring, Maryland 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 **APR 16** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 200 [ 16659 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2004 **Physician** Month Virginia Owens Reece April 13, 8:20 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 577-03-8038 90 1913 Maryland Usuel Residence of Decedent 10a. State 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits njury grother traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 20878 13431 Query Mill Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3X Widowed 4 □ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry E. Owens Melvina V. Dennison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Reece-Tomlin/Daughter P.O. Box 341, Washington Grove, Maryland 20880 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 16. 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium \* 4 □ Donation 5 □ Other (Specify) 2004 Bethesda, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. lu y M00198 0 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final **Physician** disease or condition resulting in death) Bilateral ONEUMONIA Days /Medical Due to (or as a consequence of): Examiner appendectoms Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE esn nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 20 in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tyes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 X No 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check on one Hospital: 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending death. unerel Director; A 1 Yes 2 No 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours af To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

State Registrar

Suhair Abulfarag, M.D. 31. Date filed (Month, Day, Year) **APR 16** 

Absulface

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

15215 Shady Grove Road #100, Rockville, Maryland 20850

29c. License number

031391

29d. Date signed (Month, Day, Year)

April

2004

10

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day 2004 April 10, REGNER **Physician** Martha 9:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 24, 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1□M 2□F 100 1904 Austria Director 295-14-9516 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at Silver Spring 1 Yes 2 No Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Fenwick Lane #1315 20910 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 XNo white Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Family Business permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (unknown) Sponder (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Park Valley Road, Silver Spring, MD Peter Regner, Son 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 04/14/04 Lakeside Memorial Park Miami, FL 21. Signature of Fyrmer Service Licensee Torchinsky Hebrew Funeral Home er 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Arteriosclerotic Cardiovascular Disease Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): physician at s the burial-t Box 68760 Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown jo Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certificate 2 No 2 XNo Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 XNo 3℃ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending hours after death uneral Director: / investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 29c. License number D24348 MD 4.10.2004 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Grufferman, M.D., 1500 Forest Glen Road, Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 12 2004 oaks Registrar

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of Hertificate of L	lealth and I Death		ene 2004	14661
	Physici /Medio		Decedent's Name (First, Middle,		e REITER			2. Date of Death Month April 1:	Day Year	3. Time of Death 6:15 P
)	Examin		4a. Facility Name (If not institution, g Shady Grove Adve			4b. City, Town, or Rocky i	Location of Death		4c. County of Deeth	
	Funeral Director		5. Social Security Number 6 055-05-8970		Age (In yrs. last birthday 90 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 8,	Year) 9. Birth	place (State or Foreign ntry) York
	Maryland f show	ō	Usual Residence of Decedent  10a. State 10b. County  Maryland Montg	omery	10c. City, Town or L	ocation ontgomery	Village			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the has or 28a-	Direct	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Importent: if item 27 is marked other than "naturel', or iteme 23s or 28s-1 show among injury or other traumatic event, the Medical Exam and the challing an ance.	by Funeral Director	19310 Club House  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Forces	s? ] No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	20886 ispanic Origin? (Sin, Mexican, Puerti Specify:	pecify Yes or No-	Inited Stat  14. Race - Ameri Black, White Specify: whi	can Indian, etc.
21215-0036	within 72 ho iene. than "natur the Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 10		r 5+) (Give	edent's Usual Occupa e kind of work done of DO NOT use retired omemaker	during most of wor	king 1	6b. Kind of Business/Ir	·
Maryland 2	uld be filed Mental Hygi irked other itic event,	To Be C	17. Father's Name (First, Middle, La Aaron Wo		110	memaker		ne (First, Middle, M Peicher		
	nd 2 sho aith and M 27 is ma ir trauma		19a. Informant's Name/Relationship Susan Reiter, Da			-			City or Town, State, Zin	
Baltimore,	Pages 1 and of Heinn. If item		20a. Method of Disposition  1 Surial 2 Cremation 3  4 Donation 5 Other (Spe	Removal from State	e	osition (Name of omatory or other place Memorial	1		Oc. Location - City or T Miami. FL	own, State
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Li			2. Name and Addres Corchinsky	s of Facility Hebrew	Funeral H	Home, Inc.	20012
*	Physician /Medical Examiner		23a. Part . Enter the disease, or control of the co	a	My o Condition is a consequence of):			or respiratory arres	st.	Approximate Interval Between Onset and Death
58760,	icate be executed physician and s the burial-transit	dicai Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
.O. Box (	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
<u>α</u>	w requires that the de been signed by the s should be detached t	ρχ	Part II. Other significant conditions	s contributing to death	but not resulting in the a	underlying cause give	on in Part I.		cco use contribute to to	
Division of Vital Records,	: The law requ	Completed						24a. Was an autopsy performe	prior to co	opsy findings available mpletion of cause of
Zita Zita	rsicien: Th	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	tient 2ER/Outpatie	nt 3□ DOA Othe	CHI COLUMN TO THE REAL PROPERTY OF THE PARTY	th (Check only one	ce 6 □Other (Specif	iv)
ion of	Attending Physicien: or death. ector: After this certifics by the funeral director. I	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of In (Month, D	jury 28b. Time o	of 28c. Injury Work	at	28d. Describe how		y)
Divis	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not 4 Homicide determine	ad 288. Place of it	njury - At home, farm, st atc. <i>(Specify)</i>	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Directional Completely filled in by	edical	29a. Certifier Certifying (Check only one)  Certifying  2 Medicel Ex	Physicien: To the bes eminer: On the basis and manner s	it of my knowledge, deal of examination and/or in stated.	th occurred at the tim exestigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as s e and place, and due to	tated. the cause(s)
,	1	×	29b. Signature and title of certifie	) again	<i>√</i> D-	29c. License	number		d. Date signed (Month,	**
	14		30. Name and address of person with Sunil Saxena,	no completed cause of		Print)	Rockvill	- W	bril 12, 3	150 Y
7 t	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signature	Sparks				

State of Maryland / Department of Health and Mental Hygiene

		State of Maryland	Certificate of Death	Reg. No.	14662			
		Decedent's Name (First, Middle, Last)		2. Date of Deeth Month Dey Year	3. Time of Death			
	Physician /Medical	LEOMENE RIDORE		04 10 04	12 NOON			
	Examiner	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or Lo					
		FOREST GLEN NURSING	HOME SILVER		GOMERY			
	Funeral Director	5. Social Security Number  120-56-7216    Usuel Residence of Decedent   6. Sex   7. Age (In yrs. lest in the second seco	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Yeer) 9. Birth Col. Nov. 11, 1946	nplace (Stete or Foreign intry) iti			
	laryland •how		own or Location		10d. Inside City Limits			
	tha Man 28e-fet notified	Maryland Montgomery Silv	er Spring		1 ☐ Yes 2 🖾 No			
	or 28	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	intry?			
	23a 23a ral [	10902 Bucknell Drive, #713	20902	USA				
21215-0036	72 hours after death with the Maryland 'naturel', or items 23s or 28e-f ehow dical Examiner must be notified at eted by Funeral Director	11. Maritel Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I	0 "				
2-0	ed within 72 hou lyglana.  Ver than "nature it, ir a Medical Completed	15. Decedent's Education (Specify only highest grede completed)	ie. Decedent's Usual Occupation (Give kind of work done during most of work)	16b. Kind of Business/Ir	ndustry			
21		Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workil life. DO NOT use retired)					
2	Gor that	12	Beautician	Hair St	yling			
anc	ntal Hed oth			, ,				
Z	should Individual of Mani	Lemaine Ridore  19a. Informant's Name/Relationship (Type, Print)  19	9b. Mailing Address (Street and Number or Rure	ne Clement  J. Route Number City or Town State Zi	in Code)			
<b>S</b>	ar trau	Luciane Berrouet/ Sister	10902 Bucknell Drive,					
re,	f Haa ff Haa ftem othe	20a. Method of Disposition 20b. Place	of Disposition (Name of	Date 20c. Location - City or T				
Baltimore, Maryland	parmit. Pagas 1 and 2 should be filed within Department of Health and Mantal Hygiana. Important: If Item 27 le marked other than any injury or other traumatic event, tra Mance.	Gate	of Heaven Cemetery	pril 17 2004 <u>Silver Spr</u> i	ing, Maryland			
Ba	parmi Dapa Impor any ir	*AnneMarieParker	22. Name and Address of Facility Francis J. Collins 1 500 University Blvd	.W., Silver Spring	, MD 20901			
		23a. Pert1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line.	onot enter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death			
	Physician /Medical	Immediate Ceuse (Final		1				
1	Examiner	disease or condition resulting in death)  A The Stim	al Tract Carcino	ma	unk nown			
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	ansit		a consequence of):		unknown			
Ó	an an an inial-tr	if any leading to immediate		bdominal organs unknow				
68760,	Attending Physician: The law requires that the death cartificate be asscuted riceath.  riceath.  sctor: Attar this cartificate has been signed by the attanding physician and by the funeral director, page 2 should be datached for use as the burial-transit liftcation: To Be Completed by Physician/Medical Examiner		e consequence of):	1				
	ding partific	d						
Box	that the death certined by the attending detached for use of Physician/M							
P.0.	tha di y tha iched	Part II. Other algnificant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobacco use contribute t				
σ,	ras that signed b be data by PI	anemia		1 ☐ Yes 2 ☐ No 3 ☐ Pro	obably 4 🗆 Unknown			
Division of Vital Records,	requiras been sig should by	Cardio-Respiratory F	7.5/1.01	24a. Wes an autopsy performed? 24b. W	Vere autopsy findings vailable prior to			
ပ္မ	aw requast been 2 shoul	Caralo- Respiratory 4	aciure_	co	ompletion of cause f death?			
æ	Tha I			1 1 Yas 2 1 No 1	☐ Yes 2☐ No			
/ita	vysician: Tha law lis cartificata has t I director, paga 2 s To Be Compl	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)				
7	Physic this of all dire	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/C		ne 5 ☐ Residence 6 ☐ Other (Specia	<i>fy</i> )			
n C	ing P. Aftar t funara	1 Natural 5 Pending (Month, Dey Year)	Injury Work?	28d. Describe how injury occurred				
<u>s</u>	death death tor: / the /	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home,		8f. Location (Street and Number or Run	al Route Number			
Š	tal or Attending Physis rs aftar death.  In Director: Aftar this of lad in by the funaral director: Certification: To	4 Homicide determined building, etc. (Specify)	ann, chock, restory, onlice	City or Town, State)				
_	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th complataly filled in by the funera Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge	ge, death occurred at the time, date and place, e	nd due to the ceuse(s) and manner as s	stated.			
	he Hospi in 24 hou he Funer plataly fil	(Check only one) 2 Medical Examiner: On the basis of examination each and manner stated.	na/or investigation, in my opinion, death occurre	d at the time, date and place, and due t	o the cause(s)			
	Vithi Com	29b. Signature end title of certifier	29c. License number	29d. Date signed (Month,				
	6	Chowdly, mo	D43121	04/10/2	004			
$\sim$	4	30. Name end eddress of person who completed cause of death (Item 23e NURUL CHOWDHURY, MD; 51	(Type, Print) 41 King Charles W.	ay; BeThesda, N	1020814			
	State Registrar	30. Name end eddress of person who completed cause of death (Item 23e NURUL CHOWDHURY, MD; 51  31. Dete filed (Month, Day, Year) 2004  32. Registrer's Signature	& Sparks					

DHMH 16 Rev 6/95

			1 - For State Registrar	State of	f Maryland / [	Depa <i>Cer</i>	rtment <i>tificate</i>	of H	ealth a Death	ind M	ental Hy	gien Reg. N	<sup>e</sup> 200	L	146	63
			Decedent's Name (First, Middle, Last	it)							2. Date of De	aath			Time of	Death
	Physici		Elizabeth Alice	Fribley	Rudolph						April	13.			:50	a <sup>M</sup>
3	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, 1	own, or	Location o		*	-	c. County of D			
	LAGITHI	٠.	Potomac Valley N	ursing	Home		Rock	vil]	Le			M	lontgom	ery		
	Funeral Director		5. Social Security Number 6. S 220.46.1237	ex □M 2X F	7. Age (In yrs. last bir 86	thday) Yrs.	If Under Months	Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D )ec . 10	rth ay, Year 191	9. E	Sirthplace Country)	(State or	Foreign
	σ		Usual Residence of Decedent											1		
	how		10a. State 10b. County		10c. City, Tow	n or Lo	cation								nside Cit	-
	Ba-fa	cto	MD Montgom	ery	Bethes	da										ALAINO
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	ath w	ra	4426 Chalfont Pla			1		816.		. 0 10	7. 7.		U.S.A.		dian	
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show any inury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or D	2 <b>∑</b> No ∕e		Was Decedon f Yes, spec l ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or N Rican, etc.)	0-	14. Race - A Black, W Specify: V	hite, etc.	idian,	
Ö	2 hou	ed	15. Decedent's Ed		16a.	Dece	dent's Usua	Occupa	tion			16b.	Kind of Busine	ss/Industr	у	
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2	Hygie ther ther	ပိ	17, Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maide	n Sumame)			
Maryland	Mental Arked o	To Be	Joseph W. Fri								Lou S	_	-			
Mar	nd 2 shoalth and 27 is m		19a. Informant's Name/Relationship ( Elizabeth R. Cons										or Town, State MD 208		(e)	
Baltimore,	ges 1 and of Hei		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐			ry, cirer	natory or ot	her place			ate		Location - City xandria			in
튣	r Heart		<ul> <li>4 □ Donation 5 □ Other (Specif</li> <li>21. Signature of Funêral Service Licer</li> </ul>		Mt. Co							No.	's Sons		-	IIa
Ba	Depar Depar Impo any ir		> Klanm	130	20	51	30 W1	scor	sin .	Avent	ie NW V	lash	ington			
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	bed sit	Examiner	Sequentially list conditions, I any, leading to introduct cause. Enter Underlying Cause (Disease or injury	b. Due to	or as a consactience	of):										
8760,	certificate be executed ding physician and ise as the burial-transit	dical Exar	that initiated events resulting in death) Last	Due to	(or as a consequence	of):										
Box 6	attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 Live t	tcome of pregnancy birth 2   Fetal death nant at time of death		Ectopic pro						23d. Date of Month	delivery Day	Υ	'ear
s, P.O	that the	by Phy	9 Unknown  Part II, Other significant conditions of Dementia	contributing to d	eath but not resulting i	n the u	nderlying ca	use give	n in Part I.				use contribute		37	eath?
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II Re	The law	Comp									auto pert 1  Yes	opsy formed? 2 N	24b. Were prior death	to comple ? 'es 2	No No	tuse of
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only					
	ding Phys h. After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon		utpatier Time o Intury		Bc. Injury Work		2	ne 5 Res 28d. Describe		6 □Other (S ury occurred	pecify)		
Division of	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined		a of Injury - At home, fa ing, etc. <i>(Specify)</i>	arm, sti	eet, factory	office		4	28f. Location City or To	(Street a own, Sta	and Number or ite)	Rural Ro	ute Numi	ber,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edicai C	29a. Certifier (Check only one) Cartifying Pl	<b>niner:</b> On the b	e best of my knowledge easis of examination ar oner stated.	e, deat nd/or in	h occurred vestigation,	it the tim	e, date an pinion, dea	d place, a th occurre	and due to the	cause(	(s) and manner nd place, and o	as stated due to the	cause(s)	)
	o the ithin i	Me	29b. Signature and title of certifier	11			29c	License	number			29d. D	ate signed (Me	onth, Day,	Year)	
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)	Sta		Valeria Kleshel		A. M.D. 129 Registrar's Signature	19 I	-	ton		e Si	lver S	prin	g, MD 2	20902		
.3	Regist	rar	APR 162	JU4   A	1		apo	els.								

		. For	State of Maryla	and / Dep	artment	t of Healt	th and Me	ental Hygie	ne 200	1. 11.66
		1 - State Registrar		Ce	rtificate	e of Dea	1111	Reg.	No. 200	
Physic	ian	1. Decedent's Name (First, Middle, Las	it)				1		Day Year	3. Time of Death
/Medi	cal	Wilson Rodriquez			41.02.3	Town and annual	ion of Dooth	April 13	2004 4c. County of De	1:30 A M
Exami	ner	4a. Facility Name (If not institution, given St. Mary's Hospit				Town, or Locati onard to			•	
Funeral		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthday	) If Under	1 Year If Un	nder 24 Hrs.	B. Date of Birth	St. Ma	irthplace (State or Foreigi Country)
Director		066-34-1390	<b>X</b> M 2□F 6	O Yrs.	Months	Days Hou	urs Min.	(Month, Day, Ye lay 5, 19	43 Pue	rto Rico
D >		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or L	ocation					10d. Inside City Limits
faryla ho	o.									1 ☐ Yes 2X No
28a-	Director	Maryland St. Ma	iry s	Hollywo	10f. Zip	Code		10g.	Citizen of What C	Country?
death with the Maryland me 23a or 28a-f ehow moust be notified at	JO IE	25512 Three Note	h Road		206	636			U.S.A.	
death	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Deced	lent of Hispanic	c Origin? (Spec xican, Puerto R		14. Race - Arr Black, Wh	
hours after tural; or Ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛂 No If Yes, Give		1⊠Yes 2		ecity:		Specify:	
be filed within 72 hours after death with the Marylan ital Hygiene. id other than "natural", or Iteme 23s or 28s-f show event, its Medical Examiner must be notified at	q pa	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Dece	edent's Usua	I Occupation		to Rican	Hi Kind of Busines	spanic s/Industry
d within 72 hours afi giene. or than *natural; or	piet	(Specify only highest gra		(Giv	e kind of wor DO NOT us	rk done during i e retired)	most of working	7		
d with giene	Completed	Elementary/Secondary (0-12) 8th Grade	College (1-401 5+)	La	aborer				Construc	tion
be filed value of other defends	Be (	17. Father's Name (First, Middle, Last)				18. M		First, Middle, Maid	den Sumame)	
should be file ind Mental Hy marked oth umatic event	P	Efrain Rodrique						Benitez		
C1 (0 - m		19a. Informant's Name/Relationship (	**	-1				Route Number, Ci		
ss 1 and 2 of Health item 27	-	Crystal Tharpe /		b. Place of Disp cometery, cre			n Koad		d, Mary 1  . Location - City o	and 20636 or Town, State
permit. Pages 1 ar Department of Hea Important: If item eny injury or othe once.	4	1 ☐ Burial 2 X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, cre rinsfie			4-15-	2004	1	H-11 MD
nit. Partme ortan injur		21. Signal a Comeral Service Con								Hall, MD Ome, P.A.
permit. Departi Importi eny inj		Edward N. Brinsf		00052 2	2955 F	lollywo	od Road	Leonard		ryland 2065
5 1		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.	leath. Do not er	nter the mode	e of dying, such	h as cardiac or	respiratory arrest,	interest st	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a. Respirato							Onset and Death  3 Days
/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):						
Examiner		Sequentially list conditions,	b. Pleural E:		S					2 Weeks
led hsit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	c Cirrhosis		:+b ^	maaama				( Manth
execunate and al-train	Exar	that initiated events resulting in death) Last	Due to (or as a cons		WILII P	Masarca	d			6 Months
eath certificate be executed attending physician and for use as the burial-transit	call		d							
tificat ng phy as th		IF SCHALE	_							
death certifica e attending ph	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1□Live birth 2□F	etal death 3	□Ectopic pr				23d. Date of d Month	elivery Day Year
- O O D	sici	1 Yes 2 No	4□Pregnant at time of 9□Unknown	of death 5	Other (sp	ecify)			1	Ju,
wrequires that the de been signed by the s	Ph	Part II. Other significant conditions of	contributing to death but not	resulting in the	underlying ca	ause given in P	Part I.	23e. Did tobac	o use contribute	to the cause of death?
he law requires t e has been signe ige 2 should be	d by	Hepatitis C, H	lypoalbuminem:	ia, Bil	ateral	Lung		1 🗆 Yes	<b>X</b> № 3 □	Probably 4 Unknown
The law requires that the tite has been signed by the page 2 should be detached.	lete	infoltrates						24a. Was an	24b. Were a	autopsy findings availabl
he la le has age 2	dmo	Infortraces						autopsy performed 1 Yes 2	prior to death?	completion of cause of as 2XNo
	(a)	25. Was case referred to medical				26. F	Place of Death	(Check only one)	10 101	20010
hystcian; The law his certificate has b I director, page 2 s	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1X Inpatient 2	2 ER/Outpatie	ent 3 DO	Other: 4	☐ Nursing Hom	e 5 🗆 Residence	e 6 □Other (Sp	pecify)
ing PI		27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time Injury		8c. Injury at Work?		3d. Describe how i	njury occurred	
I or Attending Phy after death. Director: After this in by the funeral d	Certification:	2 Accident investigatio 3 Suicide 6 Could not b	e Jan Plans of Injury A	At home form o	M	1 Tes		of Location (Stree	t and Number or I	Rural Route Number,
or A after of Direction by	ertif	4 ☐ Homicide determined	building, etc. (Spi	ecity)	street, ractory	, omce	20	City or Town, S	tate)	tarar riodie reditiber,
To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific; completely filled in by the funeral director.			nysician: To the best of my							
ne Ho 1 24 h ie Fui	Medical		miner: On the basis of exam and manner stated.							
To th withir To th comp	Me	29b. Signature and title of certifier		00		. License numi	ber	29d.	Date signed (Mor	nth, Day, Year)
				$M_{i}$		D51738			April 13	2004
100		30. Name and address of person who							•	
		Kae T. Aung, M.I	24435 Mer 32. Aegistrar's Si		an Roa	ad Holl;	ywood,	MaryLand	20636	
Senis	tate	31. Date filed (Month Par Year) 5	2004 32. Hegistrar's Si	-griatule	houth !	,				

DHMH 17 Rev 1/2001

ORIGINAL

				For State	State of Maryl	land / Dep		Health and M	lental Hyg	piene 2001	14665
				Registrar  1. Decedent's Name (First, Middle, La	ist)	- 06	runcate or	Death	2. Date of Dea	eg. No.	3. Time of Death
		Physicia				emshaw			APRIL	17 2004	10:10 р м
		/Medic		4a. Fecility Name (If not institution, giv		emsnaw	4b. City, Town,	or Location of Death		4c. County of Death	
		Examin	51	St. Mary's Hos	pital		L	eonardtown	1	St. M	fary's
		Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday,	Months Days		8. Date of Birth (Month, Day	y Year) 9. Birth	nplece (State or Foreign untry)
		Director		051-10-3064	1□M 2 <b>@</b> F	83 Yrs.			Sept.24	,1920 New	York
	and	3	}	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Aaryli	od a	5				M 1 1				1 ☐ Yes 2 No
	the N	28a-	Director	Maryland St.  10e. Street and Number	Mary's		Mechani 10f. Zip Code	csville		10g. Citizen of What Co	untry?
	with	3a or		38971 George F.	Drivo			20659		United Sta	ites
	death	as 2	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-		rican Indian,
ď	after	or the		1 Never Married 2 Married	1 Yes 2 No		1 Yes 2 No		110411, 010.7		nite
20	should be filed within 72 hours after death with the Maryland	- 4	d by	3 Widowed 4 □ Divorced	Year or Dates:						
4	72 h	nati	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	edent's Usual Occu s kind of work done DO NOT use retir	during most of work	ring	16b. Kind of Business/	naustry
5	withir	than	mg	Elementary/Secondary (0-12)	College (1-4or 5+)		rical Wo			Hospit	·a1
r T	# pell	Hygi ther ant.	Ö	17. Father's Name (First, Middle, Last	t)	1 016	illai wo		e (First, Middle,	Maiden Sumame)	-41
5	ed b	ked c	To Be	Anthony La Ros	a			Provid	lence Tr	ecalli	
Actimore Mentend 91915-0036	shou	Department of Health and Mental Hygiene "naturel", or Items 23a or 28a-1 show importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examination and once.		19a. Informant's Name/Relationship		19b. Mail	ing Address (Stree	at and Number or Rur	al Route Numbe	r, City or Town, State, 2	(ip Code)
2	and 2	alth a		Geraldine T. Maga	rine/ Daught	er 38971	George	F. Drive,	Mechani	csville, MI	20650
9	S 1 8	of He Item		20a. Method of Disposition  1 Burial 2 Cremation 3		Ob. Place of Disp cemetery, cre	osition (Name of ematory or other pl	ace)	Date	20c. Location - City or	Town, Stete
È	Page	ant: H		'4 □Donation 5 □ Other (Speci	rfy)	St. Fran	cis Ceme	tery 4-23	-2004	Phoenix, Ar	izona
*	permit.	Departr Importe eny inju		21. Signature of Funer I Service Live							11. Hme., P.
0		Q E 9 9	1.	Edward N. Brinsfi		0052 3	0195 Thr	ee Notch I	Rd., Cha	rlotte Hall	
		\$s		23a. Pert1. Enter the disease, or conshock, or heart failure. List only	pone cause on each line.	death. Do not er	iter the mode of dy	ring, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
		ysician		Immediate Cause (Final disease or condition resulting in death)	a	ephros	1)				
		Medical caminer		163dilling III Goddiny	Due to (or as a co	inselfuence of):	eral	obstaul	500		
		- 6	<u>-</u>	Sequentially list conditions,	b. Due to (or as a co	nsequence of):		obstruct unkno	1	,	
	petr	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Pelvic	Cara	nonc	unkno	un pr	mary	
	be executed	sician and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
757			cal	•	d						
0.5	Certificate	as th	Medi	IF FEMALE:							
3	DOX 00 auth certifica	tendir r use	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pro-		□Ectopic pregnan	су		23d. Date of deli Month	very Day Year
(	. ŏ	the at	sici	1 Yes 2 No	4 Pregnant at time 9 Unknown	of death 5	Other (specify)				<b></b> ,
		ed by the attending phy detached for use as the	Phy	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause o	even in Part I.	23e. Did to	bacco use contribute to	the cause of death?
REMSHAW	ires t	signed be de	i by	lung mas		or rooming in in-		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 🗆 Y	es 2□No 3□Pr	obably 4 Honknown
EM	requires	been sign should be	etec	Plannal F	Musions				24a. Was	24h Wara au	toney findings available
	VICAL DECOLOS,	S S	Completed	1 carron g	200000	Wa ch			autop perfor	med? death?	topsy findings available completion of cause of
ES.	1 in 12	certificate rector, pag		1VIACULOV	1) eg ener			26. Place of Dea	1 Yes	2 No 1 Yes	2 No
		recto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 DER/Outpatie	ent 3 DOA	thos		lence 6 Other (Spec	cifu)
[+]	_	h. After this e funeral dir	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time	of 28c in			ow injury occurred	,,
13	VISION	ath. r: Afte e fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	, , ,	nar) Injury		Yes 2 No			
ROSALIE		after deatl Director: In by the	Certification:	3 Suicide 6 Could not determine		At home, farm, s	treet, factory, office	9	28f. Location (S City or Tow	itreet and Number or Ru m, State)	ral Route Number,
× 5	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rs aft et Di	Cer		1 20 20 35 42/3	S1	5332				and the company
	L	within 24 hours after death.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edicai	(Check only 2 Medical Exa	hysician: To the best of marniner: On the basis of exa	iy knowledge, dea amination and/or i	ith occurred at the nvestigation, in my	time, date and place, opinion, death occur	and due to the dred at the time, o	ause(s) and manner as date and place, and due	stated, to the cause(s)
	the H	the I	Medi	one)	and manner stated.			nse number		29d. Date signed (Monti	
	70	To	-	29b. Signature and tyle of certifier	(1)	47	DI	3027	-	4-19-	
		J.		- AMU	The local control of the control of	/ (Itom 22a) /T	Print'	/		/	/
	1	1.0		30. Name and address of per an who MANOJ D PANWALA	SHAH ASSO(			20626			
35	ft -	Sta	ite	31. Date filed (Month, Day, Year)	32. Regisar's		OOD MD	20636			
A	*	Registr		APR 2	0 2004	ear D					

			1 - For State Registrar	State of Maryland		rtment of H			giene Reg. No. 20	14 14666	
	Physici /Medic		Decedent's Name (First, Middle, Last)     Leona June	Ryan				2. Date of De Month April 1		3. Time of Death 10:10 P M	
A	Examin		4a. Facility Name (If not institution, give st 1175 Scenic Way	treet and number)		4b. City, Town, or St. Leon		h	4c. County of Calver		
2	Funeral Director		5. Social Security Number 6. Sex 156–18–4553	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th 9.	Birthplace (State or Foreign Country) ew Jersey	
	Maryland f show	or	Usual Residence of Decedent	10c. City, T	own or Loc					10d. Inside City Limits 1 ☐ Yes 2X No	
	or 28a-	Director	10e. Street and Number	Dev	Leon	10f. Zip Code			10g. Citizen of Wha	t Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maryland Examiner must be nutified at once.	by Funerai	1175 Scenic Way  11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 M No If Yes, Give Year or Dates:		20685  Was Decedent of Hispanic Origin? (Specify Yes or Now Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes Wano Specify:			United St.  14. Race - / Black, V  Specify: W	American Indian, White, etc.	
215-0	ithin 72 ho	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give I life. D	ent's Usual Occupa kind of work done of O NOT use retired	lurina most of wo	rking	16b. Kind of Busine	ess/Industry	
Maryland 21215-0036	d be filed w ental Hygier ced other th c event, Inc	To Be Cor	12 – Poet  17. Father's Name (First, Middle, Last)  Vincent Franklin Lake  Poet  18. Mother's Name (First, Middle, Last)  Ida Mary Britt								
Mary	d 2 shoul th and Mari 7 is mari traumati	Ĭ	19a. Informant's Name/Relationship (Typ George R. Ryan, J	e, Print)			and Number or Ri	ural Route Numbe	er, City or Town, State  Staryland 2		
Baltimore,	ages 1 an ent of Heal nt: If item 2 y or other		20a. Method of Disposition  1   □ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	20b. Place ceme	e of Dispos etery, crem	ition (Name of atory or other place City Cem	9)	Date	20c. Location · City	or Town, State	
Balti	Departm Departm Importa any inju		21. Signature of European Septice Licenter	_	22.	Name and Addres	s of Facility Br	insfield	l Funeral	Home, P.A.	
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Meta Stati	< 123		_	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
W 7 - 5	Examiner	ner	Sequentially list conditions, b. any, leading to mini adjate gause. Enter Underlying	Melas/asv	/-	Brai	n				
,092	death certificate be executed e attending physician and nd for use as the burial-transit	icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequent	ce of):						
.O. Box 68	death certific e attending p od for use as	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  3 Ectopic pregnancy 5 Other (specify)						23d. Date of delivery  Month Day Year	
<u>a</u>	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cont	ributing to death but not resultin	g in the un	derlying cause give	n in Part I.	23e. Did to		e to the cause of death?  ] Probably 4 □Unknown	
l Records,	2 2 8	Completed						24a. Was: autop perfor 1 \( \text{Yes} \)	sy prior deat	e autopsy findings available to completion of cause of n? Yes 2 \sum No	
Vita	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	ospital:		Othe		th (Check only o	ne)		
Division of Vital	ding After fune	tion: To	1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	1   Inpatient 2   EH/	Outpatient b. Time of Injury	28c. Injury Work	at		lence 6 Other (S	Specify)	
Divis	- e -	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	28e. Place of Injury - At home, farm, street, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	cian: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the timestigation, in my op	e, date and place inion, death occu	, and due to the d irred at the time, d	cause(s) and manner date and place, and	r as stated. due to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	Or us		29c. License	number 7 5 8-8		29d. Date signed (Me April 20,		
6	M		30. Name and address of person who com			•		-1- • 1	MD 000770		
	Sta Registr		Rafik Nasr, M.D.  31. Date filed (Month, Day, Year)  APR 2 0 2	32. Registrar's Signature		cn ka. Pr	rince Fr	ederick,	MD 206/8		

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2004 18, Anthony Durk Rynties April 6:54 p.m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. St. Mary's 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F 75 Director 381-28-8897 12, 1928 Michigan Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ent: If item 27 is marked other then "natural", or items 23a or 28a-f show ury or other traumatic event, the Modical Experiment cast to notified at 1 ☐ Yes 2 No Director Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 44036 Flagstone Way 20619 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 □ No 1951- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1971 1 ☐ Yes 2 Mo Specify: Specity: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 7 Years Engineer US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alphonse Rynties ဥ Johanna Vanderhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44036 Flagstone Way, California, Maryland 20619 Dolores A. Rynties / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any njury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Brinsfield - Echols 4-20-2004 <sup>4</sup> □ Donation 5 □ Other (Specify) Charlotte Hall, MD 21. Signature of Funeral Services Lice see 22. Name and Address of Facility Brinsfield Funeral Home, P.A. chull 18 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final entricular **Physician** minute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lemic rdiomy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit VONOVU the attending physician and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown δ signed Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ma 1 🗌 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate rial 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the within 24 hours after deau..
To the Funeral Director: After this c 1 Yes 2 No 2 ER/Outpatient Certification: To 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M 00060210 20 0 MAGI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Three Notch Rd 24035 UVIV hah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2004

State of Maryland / Department of Health and Mental Hygiene 2004 14668 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Dey</sup>2004 Month **Physician** Paul Aloysius Reed, Sr. April 22, 7:03 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Maryland 214-26-8379 January 9, 1925 79 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location and Menial Hygiene. Is marked other than "natural", or Items 23a or 28a-f show reumatic event, the Medical Examiner mast be notified at 10a, State 10b. County Chaptico 1 Yes 2 No Maryland St. Mary's Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20621 USA 27541 Budds Creek Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural; or lien any injury or other traumetic avent, the Medical Examiner once. 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Local Government Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Payton Reed Mary Elizabeth Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Diane Matthews/Daughter 6706 Keystone Manor Drive Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Helen, Maryland Queen of Peace Cemetery April 30, 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Myocardial infarction resulting in death) /Medical Due to (or as a consequence of): Examiner Grenary Artery Discase Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Atherosclerosis and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical Diabetes Mellitus as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ö in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. be Hypertension 2 = No 3 Probably 4 Unknown 1 ☐ Yes peen 24a. Was an autopsy performad?

1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 NER/Outpatient 3 DOA Certification; To 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? After : or Attending 1 ANatural 5 Pending М 1 Tyes 2 No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a Brill D. 22159 April 23, 2004 30. Name and address of erson who completed cause of death (Item 23a) (Type. Print)
Eugene Guazzo, M.D. Maryland infirmary Maryland infirmary, Chaptico, MD 20621-0002 31. Date filed (Month, Day, Year)
APR 2 6 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 5:03 PM 13, 2ďď4 **Physician** Louis Philip Russell Sr. /Medical 4a. Facility Neme (If not institution, give street and number)
Holy Cross Hospital 4b. City, Jown or Location of Death Silver Spring, Md. Montgomery Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | Feb. | 1 / 1 / 33 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign 5. Social Security Number 162-28-8607 6. Sex **Funeral** 1 🕱 M 2 🗆 F Pennsylvania Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 1e 10a State 10h County r than "natural", or items 23s or 28s-f show the Medical Exempler must be notified at 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 20782 10g, Citizen of What Country? 10e, Street and Number 6040 Sargent Rd. # 4108 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene important: If item 27 is marked other than "natural; or item any injury or other traumstic event, the Medical Exempted 2002. 1 TXes 2 No 2/55 1 Never Married 2 Married If Yes, Give Year or Dates: 3/53 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specity: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Government State Department Elementary/Secondary (0-12) College (1-4or 5+) Foreign Service Officer 18. Mother's Name (First, Middle, Maiden Surmame)
Alice Williams 17. Father's Name (First, Middle, Last) Be George Russell 19a. Informani's Name/Relationship (Type Print) Bessie L. Russell 19b. Maijing Address (Street and Number of Bural flouts Number, City of Town, State Fin Code) 6040 Sargent Rd. # 4108, Hyatts Ville Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 04 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) April 19, Washington, D.C. Mt. Olivet 21. Signature of Funeral Service License 22. Name and Address of Facility Robinson Funeral Home 1313 6th ST. N.W. 20001 D.C. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Pulmonary Disease Chronic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physicien Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 🗆 No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 Yes 2□ No 1 Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 💢 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 2 ER/Outpatient 3 DOA Certification; To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending s after de... at Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) mi April 13, 04 D41624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holy Cross Hospital Silver Spring Md. Patrick Murphy, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 6 2004 Registrar

Harold S. Roots Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 04 - 2425AKG Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 3:50 P M April 8, 2004 Harold S. Roots /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 542 East Indian Springs Drive Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1X M 2□ F Director 579-72-8178 49 Sep. 5, 1954 Wash., DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rei', or itams 23a or 28a-f ehow Examiner must be notified at 1 TYPes 2 □ No Directo Montgomery Maryland| Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 542 E. Indian Springs Drive 20901 <u>United States</u> Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours affer inent of Health and Mental Hygiene. ant: If Item 27 is marked other than "naturel", or Ital 1X Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Communication Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Odessa Roots Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Roots - Sister 6430 - 6th St., N.W. Wash., DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 'Department of Himportant: If ite eny injury or of once. 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 4/17/2004 Suitland, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 oun (DUCKS) Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Contact gurslot would **Physician** resulting in death) /Medical **Examiner** Sequential vilist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Pther (Specify) At SCENE 1 X Yes 2 □ No 2 P 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending Subject short see 1 ☐ Yes 2 No death. 10 Y investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 542 East 14618 3√ Suicide 4 ☐ Homicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Drive, Silver Spring, MI 16. RSilleuce To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ineles April 9, 2004 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZABISCLAG 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 6 2004

. Registrar's Signature-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 5:50 ам **Physician** hobbs 2004 son Dril /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give st Examiner Linton Georges Maryland outhern If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months M 2□F South Carolina 4362 251 10 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No lemple Frince reorges Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? States 70748 2002 ameson United Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? or Itams 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or liter any injury or other traumatic event, the Maulical Egarithmet. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Covernment Elementary/Secondary (0-12) College (1-4or 5+) tolice year 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) inhnown lannie unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39a. Informant's Name/Relationship (Type, Print) wife 2004 Jameson St. Hills MO hobbs lemole nosena Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Bladerslaura 04 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licenses 22. Name and Address of Phines Funeral Home Washington DC 20017 John 1. 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) e pt icomia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Clure 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No 1 ☐ Yes Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 ☐ Yes 2 ☐ No 1 / Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) napital or Attanding Physnous after death.

naral Director: After this y filled in by the funeral di 27. Manner eath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 104

DHMH 17 Rev 1/2001

State

Registrar

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

bushern

1328

31. Date filed (Month, Day, Year)

APR 1 6 2004

State of Maryland / Department of Health and Mental Hygiene  $200\,$ Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10:00 a M April 2004 Robert F. Robey, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Crescent Cities Center Riverdale If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months **Funeral** 1 → M 2 □ F May 14. 73 1930 Virginia Director 229-34-6200 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Hygiene. other than "naturel", or items 23a or 28e-f show ent, the Modical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2 No Maryland Howard Elkridge Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21075 8031 Keeton Road U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ty Yes 2 No 1950—
If Yes, Give
Year or Dates: 1953 within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Giant Food, Inc. 11 Seafood Manager permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg
Important: If item 27 is marked other
eny injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert F. Robey, Sr. Nellie Elizabeth ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8031 Keeton Road, Elkridge, MD Peeggee V. Day - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 04/15/2004 Alexandria, Virginia <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4739 Baltimore Ave., Hyattsville, MD 20781 andette 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician Atherosclerotic Cardiovascular Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending for use as as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ሺ Unknown Renal Insufficiency; Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an End Stage Dementia autopsy performed? Yes 2 No certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 tnpatient 2 EP/Outpatient 3 DDA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2K No 2 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aff To the Funeral Di completely filled in f 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cent D48213 April 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4410 74th Avenue, Landover Hills, MD Neelam Ashai, M.D.,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 6 2004

ORIGINAL

32. Registrar's Signature

unpend item#23a,27,Per Me,C831,5/18/Oveg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Nancy A. Rambo State of Maryland / Department of Health and Mental Hygienes 04 - 2703**AKG** Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician Year Nancy Ann Rambo 19, /Medical April 2004 11:29 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Center Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🙀 F 216-64-3754 47 Director 10/25/1956 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner roust be notified at 1X Yes 2 □ No Director Maryland Prince Georges **Hyattsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with Hygiene.

Hygiene. 5917 Gallatin Street 20781 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2☐No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker t and 2 should be filed w Health and Menta! Hygier tem 27 Is markad other th Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 David R. Miller Rose Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If item 27 is Dana Rambo 5917 Gallatin St; Hyattsville MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincon Cemetery 4/26/2004 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Myslin T. Wobert MO1322 3401 Bladensburg Road; Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovasdlar Disease Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed ng physician ar as the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. I 9 Unknown sete has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No autopsy performed? 1 Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Xes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funerel Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel To the twithin 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Greenberg Tousha O.C.M.E. April 20, 2004 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Dera 31. Date filed (Month, Day, Year)
APR 2 8 2004 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

	1 - State Registrar  1. Decedent's Name (First, Middle, La	State of Ma	ryland / Dep <i>Ce</i>	artment of I rtificate of	Tealth and N Death		ene 2004	3. Time of Death
/sician ledical	Taylor	Robinson		4h Cihi Tourn	or Location of Death	Month 4	Day Year 2009	1 9:40 A
aminer eral ctor	5. Social Security Number	HARE HOS	Spilal (In yrs. last birthday) Yrs.	Rose If Under 1 Year Months Days	da le If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	BAITI y (ear) 9. Birth	
ctor	Usual Residence of Decedent  10a. State 10b. County  D • C •		10c. City, Town or L Washing					10d. Inside City Limit
Director	10e. Street and Number 1812 Potomac A	Tropuo S	T.	10f. Zip Code	103		g. Citizen of What Co United S	-
edical Exacting must be rotified at	11. Marital Status 1X Never Married 2 ☐ Married	12. Was Decedent Examed Forces?  1	ver in U.S. 13.		Hispanic Origin? (Span, Mexican, Puerto		14. Race - Ame Black, White	rican Indian,
			(Give		oation during most of work d)	king	6b. Kind of Business/l	Industry
Be	17. Father's Name (First, Middle, Las	1)	NO	ne		ne (First, Middle, Ma na Robin		
other traumatic	19a. Informant's Name/Relationship Sarah Robinson		other 18	312 Poto	omac Ave	., SE, V		on, DC
any injury or otr Once.	20a. Method of Disposition  1	fy)	Se	ake Cre	matory 4	1/19/04	Beltsvil essional NW	le.MD
ian cal	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line a. K+rcz	he death. Do not en				it,	Approximate Interval Between Onset and Death
e ourial-transil		c	consequence of):					
by Physician/Medica		23c. If yes, outcome o  1  Live birth 2  4  Pregnant at ti	23d. Date of deli	very Day Year				
		contributing to death but	t not resulting in the t	ınderlying cause gı	ven in Part I.	23e. Did toba	cco use contribute to	
Completed						24a. Was an autopsy performe	prior to o death?	topsy findings availab completion of cause of
Be Betor	25. Was case referred to medical examiner?	Hospital:				th (Check only one)		
		28a. Date of Injury (Month, Day	t 2 ER/Outpatie  / 28b. Time of Injury	of 28c. Inju		ome 5 Residence 28d. Describe how	ce 6 □Other (Spec rinjury occurred	ify)
illed in by the tuneral Certification:		building, etc.				City or Town,		
completely filled	29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa one)  29b. Signature/and title of certifier	rhysician: To the best of iminer: On the basis of and manner state	examination and/or in		opinion, death occur	rred at the time, date		to the cause(s)
0	30, Name and address of person the	completed cause of de	ath (Item 23a) (Type	BE,	50000	0	04/12/0	4
State	Dr. ERICA Sine	gle mann 3 32. Registrar	1000 Fran	Klin Squ	care Driv	e Baltim	ore, Md.	21237

DHMH 17 Rev 1/2001

BAby girl

			For State Registrer	State o	of Maryland	d / Depa <i>Cer</i>	artment of H tificate of L	ealth and Death	Mental Hy	/giene Reg. No.	004	14675
			1. Decedent's Name (First, Midd	lle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physici /Medio		Thomas E	. Shor	ctall, J	r.			April		004	4:50 PM
	Examin		4a. Facility Name (If not institution	on, give street and nu	ımber)		4b. City, Town, or	Location of Dea	th	4c. County of Death		
н			201 South Uni	versity Av	venue		Federals				aroline	
	Funeral Director		5. Social Security Number 216–38–8840	6. Sex 1 X M 2 □ F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min		irth lay, Year) > 28.10	9. Birthp Coun	lace (State or Foreign itry) yland
			Usuel Residence of Decedent						December	ريرانك يا		
	how		10a. State 10b. County	У	10c. City	, Town or Lo	cation				1	0d. Inside City Limits  Yang 2 □ No
	8e-1 s	Director		ROLINE		FEDER	ALSBURG					
	vith th	Die	10e. Street and Number	rren arrens Lr	7 PM N T T T T T T T T T T T T T T T T T T		10f. Zip Code	(22		10g. Citize	on of What Cour	itry?
	s 23e	eral	201 SOUTH UNI		/ KNUK cedent Ever in U.S	9 12 1		632	Specify Ves or N	0- 14	USA I. Race - Americ	an Indian
36	be filed within 72 hours after death with the Maryland tal Hygiene.  do other then "naturel", or Itams 23e or 28e-f show event, the Medical Exarting roual be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Ma  3 □ Widowed 4 □ Divorce	rried Armed F	orces? 2		Was Decedent of Hispanic Origin? (Specify Yes f Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2X No Specify:				Black, White,	
Ö	72 ho	ted	15. Decede	nt's Education est grade completed;	1	16a. Deced	ient's Usual Occupa	ition	orkina	16b. Kind	d of Business/Inc	dustry
21215-0036	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life. I	DO NOT use retired,	)			DIESEL	
d 2	filed withir Hygiene. other then ent, the M		17. Father's Name (First, Middle				BOIRINIO	18. Mother's Na	me (First, Middle	e, Maiden S		
Maryland	2 should be to and Mental   is marked o raumatic eve	To Be	THOMAS E. SHO	RTALL, SR.				AGNES	VIRGINIA	a BROO	KS	
ary	s me	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street a	nd Number or A	ural Route Numi	ber, City or	Town, State, Zip	Code)
	D = 2 =		SHIRLEY SHORT.	ALL/WIFE				IVERSIT				, MD 21632
ore			20a. Method of Disposition 1	3 □Removal from	1 0	lace of Dispo emetery, cren	sition (Name of natory or other place	9)	Date	20c. Loca	ation - City or To	wn, State
Baltimore,	nit. Pages artment of h ortent: If its injury or of		`4 □Donation 5 □ Other (	Specify)	MD '		ns cemete		6-2004	HURL	OCK, MA	RYLAND
Bal	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service	S. MEI	RCERO	FE	Name and Addres LLOWS, HE OS. HARR	LFENBET	N & NEWN	NAM FU	NERAL H	OME P.A.
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that it only one cause on	caused the death each line.							Approximate Interval Between Onset and Death
п	Physician	ľ	Immediate Cause (Final disease or condition	-a. 4	MOCON	dial	In	arcti	00			Oriset and Death
н	/Medical Examiner		resulting in death)	Due to	(or ) a consequ	ience of):						
		e e	Sequentially list conditions,	b	(or as a consequ	ience of):						So Mar H
7	uted d ansit	Ē	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>	11.77							
Ć.	exection and and rial-tra	Examin	resulting in death) Last	cDue to	(or as a consequ	ence of):						
8760,	cate be executed physician and the burial-transit	dlcal		d								
9		Med	IC CCMALE:									
О. Вох	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   1   Unknown   2   Unknown   2   Volume   2   Volum							23	d. Date of delive Month	ny Day Year
<u>α</u>	res that igned b be deta	by Pt	Part II. Other significant condit	tions contributing to	death but not resu	ulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use		e cause of death?
ğ	w require been sig should b	ted	a-4p						1 🗆	Yes 2□	No 3 Prob	ably 4 □Unknown
Vital Records,		Completed							24a. Wa auto peri 1 ☐ Yes	s an opsy ormed? 2 No	prior to cor death?	psy findings available npletion of cause of 2 No
/ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to medic examiner?						ath (Check only	one)		
<b>→</b>	dis di	P	1 ☐ Yes 2 ☑ No			ER/Outpatien		4 U Nursing			Other (Specify	1)
'n		lon:	27. Manner of Death  1 ☑Natural 5 ☐ Pend	nig .	nth, Day Year)	28b. Time of Injury	Work	at ? ∕es 2 ∐No	28d. Describe	now injury	occurrea	
Division	tand beath tor: the	ficat	3 ☐ Suicide 6 ☐ Could		e of Injury - At ho	me, farm, str			28f, Location	(Street and	Number or Rura	l Route Number,
DΪ	after after I Dira	Certification:	4  Homicide deter	mined 200. Fiac	ding, etc. (Specify	")	,,,		City or To	own, State)		
	To the Hospital or Attanding within 24 hours after death.  To tha Funaral Diractor: After completely filled in by the fune	Medical C		ing Physicien: To the								
	To th withir To th comp	Me	29b. Signature and title of certifi	ier			29c. License	number		29d. Date	signed (Month,	Day, Year)
			1/11/	-			D'	53394		*_1	Halla	400
				n who completed cau				\\	7.	<	se i No	105
			Dr. Anthon 31. Date filed (Month, Day, Yea	1 1	Registrar's Signat		05 Her	nberto Nsbury		SIE	olive	100
	Regist	ate rar	APR 22	2004	in A	fol	The state of the s		71	3/13	O1	

State of Maryland / Department of Health and Mental Hygiene ? For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear Month **Physician** 2:34 A M 23, 2004 STETLER Apri1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Convalescent & Rehab Center Crofton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 9, 1915 Iowa Director 479-07-2599 88 Dec. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral', or Itams 23a or 28a-f show Examiner must be nutified at 1 XYes 2 No Director Maryland Prince Georges Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 2, any injury or other traumatic event, tra Medical Examinating pages. 20720 U.S.A. 8236 Ouill Point Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leo DeLaney Theresa James Cahalan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Stetler/ Daughter 8236 Quill Point Drive, Bowie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Gate Of Heaven Silver Spring, Maryland 4/26/2004 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee got Phini 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Spination Mumonia WECKS Physician /Medical Due to (or as a consequence of): Examiner ement Tecro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed2 2 🗌 No 2 X No 1 Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Injury at Work? After t Certification: of or Attending Patter death. 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funaral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane, Suite 222, Bowie, Maryland 20715 Rakesh Arora, M.D. 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State APR 2 6 2004 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar	State of	Maryland / Dep Ce	artment of Fertificate of	lealth and N Death		giene2 ( Reg. No.	104	14677
MA 6	Physici	/ <del>**</del> 0	1. Decedent's Name (First, Middle, L Robert Sloan Sa			, .		2. Date of Dea Month April	Day	Year 4	3. Time of Death  12:29A M
	/Medic Examir	- 3	4a. Fecility Name (If not institution, g Washington Adv	ive street and num		4b. City, Town, or Takoma F	Location of Death	1	4c. County of Death  Montgomery		
	Funeral Director				. Age (In yrs. last birthday			8. Date of Birt (Month, De July 1	h	9. Birthp	lace (State or Foreign
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgon	mary	10c. City, Town or L					1	0d. Inside City Limits
	with the a or 28a.	Direc	10e. Street and Number	псту	ROCKVIII	10f. Zip Code 20852			10g. Citizen o	d Sta	,
036	within 72 hours after death with the Maryland ene. then "naturel", or litems 23e or 28e-f show to Medical Examana thust be neitified at	Completed by Funeral Director	802 Brice Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Ford	1 Xi Yes 2 D No		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici			ace - Americack, White,	can Indian, etc.
21215-0036	ed within 72 ho rgiene. er then "netu	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	completed) College (1-5+	4or 5+) (Giv	edent's Usual Occup e kind of work done DO NOT use retired School Te	k done during most of working e retired)  1 Teacher			c Sch	County
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other then "traumatic event, it a Metal	To Be	17. Father's Name (First, Middle, La  Robert Stillson  19a. Informant's Name/Relationship	Sanford	19h Mai	ling Address (Street	18. Mother's Nam  Grace S1	Loane			a Code)
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "nature!, or items 23a or 28a-f show any injury or other traumatic event, it a Medical Example in the halling an once.	5	Bonnie Gitlin/Da  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	aughter □Removal from S	20b. Place of Displace of Montgome Cremator	Founders position (Name of ematory or other place ry ium. Inc.	Way, Dan (2004) April (2004)	mascus, Date 11 20,	Maryla 20c. Location Betheso	nd 20 n - City or To	0872 own, State
8760,	Physician and // Medical Examine and sthe buriar-transit	dical Examiner	23a. Pert1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	used the death. Do not en	nter the mode of dyir					Approximate Interval Between Omset and Death
P.O. Box 6	requires that the death certifit een signed by the attending f nould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bir	int at time of death 5	□Ectopic pregnancy □ Other (specify)	1			Pate of deliver	ery Day Year
	v requires that been signed b should be deta	5	Part II. Other significant conditions	contributing to dea	tributing to death but not resulting in the underlying cause				obacco use co Yes 2 □ No	ntribute to tl	ne cause of death?
Vital Records,	The law ate has b page 2 st	Completed						24a. Was autop perfo 1 ☐ Yes	an 24b osy ormed? 20 No	were auto prior to co death? 1 \( \text{Yes}	psy findings available mpletion of cause of 2 No
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	patient 2 ER/Outpati	ent 3 DOA Oth	er: A D Nursing H	th <i>(Ch</i> ec <i>k only c</i> ome 5 ☐ Resid		ther (Specif	(v)
Division of	nding ath. r: After e fune	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date o (Month		of 28c. Injut	y at	28d. Describe			,,
Divis	lospital or Atte thours after des uneral Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of buildin	of Injury - At home, farm, s g, etc. (Specify)			City or Tov	wn, State)		al Route Number,
	To the Hosp within 24 hou To the Fune completely fi	Medical	(Check only 2 Medical Ex		best of my knowledge, des sis of examination and/or er stated.		pinion, death occur	rred at the time,		e, and due to	the cause(s)
	10+1	-	29b. Signature and title of certifier		Dee	4	01/9		Apri	1,17	12004
	•	210	Steven Boyce,  31. Date filed (Month, Day, Year)	M.D. 10	6 of death (Item 23a) (Type 6 Irving Str gistrar's Signature		, Washing	gton, D.	C. 200	10-299	)3
)	St	ate	31. Date filed (Month, Day, Year)	2004	4	han 11					

			1 - State of Maryland / Dep Registrar	artment of Health and Mertificate of Death	lental Hygie		14678
	Physici		Decedent's Name (First, Middle, Last)     LEONARD C SEIDEN		2. Date of Death Month APRIL 17	Day Year	3. Time of Death 4:45 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) HEBREW HOME	4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 088−12−6578 1√2 M 2□ F 83 Yrs.		8. Date of Birth (Month, Day, Ye DEC 4, 19	MONTGOME 9. Birth Cou	place (State or Foreign
			Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation	DEC 4, 1:		10d. Inside City Limits
	he Many 8a-f sh	Director	MARYLAND MONTGOMERY SILVER S		1		1 Yes 2 No
	th with t		3330 NORTH LEISURE WORLD BLVD APT 92	10f. Zip Code 21 20906		Citizen of What Cou JNITED STA	•
980	hours after death with the Maryland turel; or Itams 23e or 28e-f show al Exercit set must be recitified at	by Funerai	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WH]	etc.
Maryland 21215-0036	within 72 ane. than nai	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation b kind of work done during most of worki DO NOT use retired) EACHER	ng	Kind of Business/In	dustry
nd 2	Hys th	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid		
aryla	should and Mer s marke umatic	ပ	DAVID SEIDEN  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	YETTA ing Address (Street and Number or Rura	FINGER	ly or Town, State, Zip	Code)
	1 and 1 and		BETTY SEIDEN (WIFE) 3330	NORTH LEISURE WOR		21, SILVER	
Baltimore,	Page Internation		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Matory or other place) ARK CREMATORY 4-23-		ALTIMORE,	
Balt	permit. Departr Importa sny inji		21. Signifure of Funeral Service Licensee	2. Name and Address of FacilityHINF 1800 NEW HAMPSHIRE SILVER SPRING MARYI	ES-RINALDI AVENUE LAND	FUNERAL	HOME INC
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	11	4		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)  a. Due to on as a consequence of):	Travi	Diseas		
	*	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.	my Arten	Blelan	e	
oʻ	be executed sicien and burial-transit	Exam	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
68760,	rificate be ex ig physicien as the burial	edical	d				
О. Вох	ne death cer the attendir thed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown		23d. Date of delive Month	ory Day Year	
Records, P.	w requires that the base of the part of th	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the	ne cause of death?
al Reco	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed' 1 ☐ Yes 2 ☐	prior to cor death?	psy findings available inpletion of cause of 2 No
of Vital	di Si	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death nt 3□ DOA Other: 4 D Tursing Hon		6 ☐Other (Specif)	1)
ion	Attending Ph r death. ector: After th by the funeral	ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
Division of	al or Attend after death Director: / d in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 2	18f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
	o the Hospital or Attending thin 24 hours after death. The Funeral Director: After mpletely filled in by the funer	Medical C	29a. Certifier (C-leck only one)  1 Certifying Physician: To the best of my knowledge, deatled the control of the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause ed at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
)	To the R	Me	29b. Signature and title of certifier  Con Colombia MD	29c. License number D 24942	29d. E	Pate signed (Month,	Day, Year) 7 2004
			30. N me and address of person who impleted cause of death (Item 23a) (Type,	Print) W 6121 M	whise	RI Ro	ckrill 41
	Sta Registr		31. Date filed (Month, Day, Year) APR 20 2004  32. Degistrar's Signature	Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month Day Yee **Physician** APRIL ALBERT SHEER 16, 2004 3:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 XM 2 F 93 Yrs. 1910 NEW YORK 132-03-3385 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Directo MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #329 or items 23a 3701 INTERNATIONAL DRIVE 20906 UNITED STATES OF AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates 1940 – 44 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No WHITE Specify þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) CREDIT & COLLECTIONS OFFICE SUPPLY permit. Pages 1 and 2 should be filed wi Department of Health and Mentai Hygien Important: If Item 27 is marked other th any injury of other traumatic event, Use once. other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LOIUS J. SHEER ANN HELFAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) RICHARD M. SHEER - SON 12412 FROST COURT, POTOMAC, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GARDENS 04/18/04 \* 4 □ Donation 5 □ Other (Specify) OLNEY, MARYLAND 21. Signature of Funeral Service Licensee EÓWARD SACEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovaswlerr **Physician** /Medical Due to (or as a consequence of): Examiner Hypertension Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner diseaue The law requires that the death certificate be executed buriai-transit rona the attending physician and Box 68760 neumonia. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of daath? þ Division of Vital Records, nemma 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy rmed? 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Dispatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29b. Signature and 29c. License number

State
Registrar

30. Name and address

31. Date filed (Month, APR

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2004

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Beltiesda,

20817.

person who completed cause of death (Item 23a) (Type, Print)

320

32. Registrar's Signature

		1	For State	State o	f Marylan	-	artment of H		nd Men	tal Hygie	2011	14680
_			Registrer  1. Decedent's Name (First, Middle, I	ast)			imodio oi z	Joann		Date of Death		3. Time of Death
	°Physicia	n	Cleo		rates					Month oril 18	. 2004	3:00 am
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of			4c. County of Dea	th
	%.	13 65	18016 O'Hara	Circle			01ney				Montgo	mery
	Funeral		5. Social Security Number 6	Sex 1 □ M 2 🔀 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (	Date of Birth Month, Day, Ye	9. Bir (Co	thplace (State or Foreign ountry)
ı.	Director	-	578-40-8372 Usual Residence of Decedent	- 11	73	,,,,,				an. 22,	1931 Ne	w York
	land ow	-	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	Many a-f sh	ţċ	Maryland Baltim	ore	P	arkton						1 ☐ Yes 2X No
	th the	lrec	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Co	ountry?
	236 unit b	la l	2001 Mount Car				21120				USA	ning Indian
	tems	nue	11. Marital Status	Armed Fo		.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origi n, Mexican,	Puerto Rica	Yes or No- n, etc.)	14. Race - Ame Black, Whi	te, etc.
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi Year or D	Ve		1 ☐ Yes 2 🎽 No	Specify:			Specify: Wh:	ite
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or tlems 23s or 28a-f show sther then "neturel", or tlems 23s or 28a-f show snt, tre Madical Exertil were nut be redilled at	ted !	15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ation	of working	16	b. Kind of Business	/Industry
212	hin 72	ple	(Specify only highest Elementary/Secondary (0-12)	College (		life.	kind of work done of DO NOT use retired	i)	or working			
21	od wit	Com			4	Hor	nemaker	40.14-4-4	- N - /F		Own Home	
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, La							rst, Middle, Mai		
<u>Ş</u>	nould 1 Men narke netic	은	Kyriakos John 19a. Informant's Name/Relationship		5	19h Maili	ng Address (Street a			matatis oute Number C		Zip Code)
<u>a</u>	d 2 st th and 7 is n treun		Anna M. Strate		ghter		16 O'Hara					,
<u>6</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23s or 28a-f show eny injury or other treumetic event. If a Madical Exercite Remainer of once.	1	20a. Method of Disposition		20b. I	Place of Disp	osition (Name of matory or other place		Date	20	c. Location - City or	r Town, State
JOE	ages ent of		1 ⊠ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe				Heaven etery	1	Apr <b>il</b> 2004		ilver Spr	ing. MD
Baltimore,	mit. F partm porter / injui		21. Signature of Funeral Service Li		20	2	<ol><li>Name and Address</li></ol>		1-700000			
m		19	inchen	) > HC	ele	5	rancış J. 00 Univer	sity	${}^{\mathrm{ins}}_{\mathrm{Blvd}}$ .	W., Si	lver Spri	ng, MD 20901
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that nly one cause on	caused the dea each line.	th. Do not en	ter the mode of dyin	g, such as c	cardiac or res	spiratory arrest	•	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Seps								3 Months
	/Medical Examiner		resulting in death)		(or as a consec							
В	LAdimiei	la.	Sequentially list conditions,	b. Card	iopulmo	nary F	ailure					2 Months
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(0. 20 2 00.100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	ate be executed hysician and he burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a conse	quence of):						
1760,	ysicial ysicial	call		d								
89	tificat ng phy as th				111		-			3.7		
Вох	death certificat e attending phy d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn birth 2 - Fet	al death 3	☐Ectopic pregnancy	,			23d. Date of de Month	elivery Day Year
	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Preg 9□ Unki	nant at time of nown	death 5	Other (specify)					,
P.0	t t		Part II. Other significant condition	s contributing to	death but not re	sulting in the	underlying cause giv	en in Part I.		23e. Did toba	cco use contribute	to the cause of death?
ds,	es Be	d by	Squamous Cell C							1 🗌 Yes	2 <b>⊠</b> No 3□F	robably 4 Unknown
Record	> 12 0	ompleted	Dquamo as see							24a. Was an	24b. Were a	utopsy findings available
Rec	e la has ye 2	dmo								autopsy performe 1 Yes 28	d?   death?	
Vital	icien: Th certificate ector, pag	CO	25. Was case referred to medical					26. Place	of Death C	heck onl one	110	M. 1 - 1 - 2 - 2 - 3
<u>=</u>	S S	O B	examiner? 1 ☐ Yes 2 🖾 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	er: 4 🗆 Nur	rsing Home	5 🗆 Residend	ce 6 √Other (Sp	laughter's
n of		nc.	27. Manner of Death 1   Natural 5 □ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time Injury	Wor			. Describe how	injury occurred	
Siol	Attending r death. ector: Aftei by the fune	catle	2 Accident investiga	ation				Yes 2□N		Location /Stro	ot and Number or 6	Rural Route Number,
Division	or Att	ertification;	3 Suicide 6 Could not determine determine	1ed 288. Plac	ce of Injury - At I ding, etc. (Spec		treet, factory, office		201.	City or Town,		nulai noute vuinoei,
	To the Hospitel or Attendi within 24 hours after death.  Vo the Funerel Director: A completely filled in by the fu	0	29a. Certifier 1X Certifying	Physician: To the	ne best of my kir	nowledge, dea	th occurred at the tir	me, date and	d place, and	due to the cau	se(s) and manner a	as stated.
	B Hos 24 ht B Fun etely	edical	(Check only 2 Madical E	xaminer: On the	basis of examin nner stated.	nation and/or i	nvestigation, in my o	pinion, deat	th occurred a	at the time, date	e and place, and du	ie to the cause(s)
	To the within Fo the complex	Me	29b. Signature and title of certifier	~ /			29c. Licens			290	. Date signed (Mor	nth, Day, Year)
	1						- 4	455	9		April 1	9, 2004
	()		30. Jame and address of person v									
			Alan Dean Aar				sin Avenu	e, #60	04, Ch	evy Cha	ase, MD 2	0815
	St Regist	ate	31. Date filed (Month, Day, Year) APR 21 2		Registrar's Sign	Jature, L	Sparks	/				
	- ( - ) -   ( - )				F 7		1-1					

Amend Item #20c, Per F.D., 04/14/2004, Carroll County,cew Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year MARY CAROLINE SNYDER APRIL 11, 2004 4:57 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CARROLL 58 CHASE STREET WESTMINSTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign OCTOBER 23,1919 MARYLAND Months Days Hours 1 M 2 XX 214-20-2885 84 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examin ar must be notified a 1 XYes 2 ☐ No Director WESTMINSTER MARYLAND CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 UNITED STATES 58 CHASE STREET Iteme 23a Funera 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☐ No 3₩idowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) TOOL MANUFACTURER ASSEMBLY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY FARR GIBSON JOHN CONRAD BOERNER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or other tra 58 CHASE STREET, WESTMINSTER, MD WILLIAM GLAZIER, JR./NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) FAMPSTEAD TOWN State 1XXBurial 2 Cremation 3 Removal from State SHILOH METHODIST CEMETERY HAMPSTAED, \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoo or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Im nedian Cause (Final disease or condition resulting in death) Physician BROST Cancer XX3X /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine sician and burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Who 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Month Year 4 Pregnant at time of death Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Mann r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M 2 Accident investigation 6 Could not be determined

or Attanding Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. filled in by the funeral after death.

within 24 hours a To the Funerel I the Hospital

State Registrar

Medical

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

00357943

30. Name and address of person completed cause of death (Item 23a) (Type, Print)

JOHN C. ABEL M.D. 295 STONER AVENUE, WESTMINSTER, MD 21157

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier (Check only one)

4 - Homicide

2004

32. Registrar's Signature

			For State ANTEND#260004001	State of Maryla			of Health a	ınd Men	tal Hygie	ne 2004	14682
			- State Registra AVEND#26perMD4/  1. Decedent's Name (First, Middle, Last		Ce	runcate	oi Death	2 0	Reg.	No.C. O O S	
	Physic		Albert Shaneman	,				, N	fonth	Day Year	3. Time of Death
}	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of		ril 14,	4c. County of Dea	3:55 A M
			Holy Cross Hospit	al		Silve	r Spring			Montgome	
	Funeral	Г	5. Social Security Number 6. Se		rs. last birthday)	If Under 1		24 Hrs. 8. D Min. (A	ate of Birth Month, Day, Ye		thplace (State or Foreign ountry)
	Director		213-54-9864	51	Yrs.		Jays Hours		r 28, 1		hington, DC
	land ow		Usuat Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
	Mary Fresh	to	Maryland Montgom	0.777	C	<b>-</b>					1 Yes 2 No
	h the	irec	10e. Street and Number	ery 5	ilver S	10f. Zip C	ode		10g.	Citizen of What Co	puntry?
	72 hours after death with the Maryland netural", or Items 23a or 28a-f show dieal Examinar must be notified at	Funeral Director	14102 New Hampshi	re Ave		20	904			USA	
	sr des	nue		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceder	t of Hispanic Origi Cuban, Mexican,	in? (Specify Y	es or No-	14. Race - Ame Black, Whit	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		1 Yes 2			, ,	Specify:	e, <del>0</del> 10.
21215-0036	2 hours	edt	15. Decedent's Edu	===11 77-1	16a, Dece	dent's Usual (	Occupation		166		hite
215	hin 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)		(Give		done durina most d	of working	100	. KIIIU OI BUSINESS	industry
7	filed within Hygiene. other then ont, the Me	Com	alonomary/socondary (0*12)	3	P1.	anner				Land Use	
nd	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name (Firs	t, Middle, Maid		
<del>y</del> la	should nd Men marke umatic	ဥ	Albert F. Shaneman				Rut	th Hasl	cayne		
Maryland	d2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (Ty							ty or Town, State, 2	
	1 and Health Iem 27		Barbara Preller/L: 20a. Method of Disposition		14102 . Place of Dispo	2 New I	lampshire	e Ave		Sprin. Location - City or	
OL.	Pages nent of I int: If its		1 ☐ Burial 2 XCremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cren	natory or othe	r place)				
Baltimore,	그 든 말 금		21. Signature of Funeral Service Qicenso	1 11	oudon Pa	ark Cre	ematory Anddress of Facility	Apr 18,	20 <u>04</u>	Baltimon i Funeral	re, MD
ä	Department Department		Laupa Di	turnes							г ноте ng, MD 20904
8,			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the de	ath. Do not ente	er the mode o	f dying, such as ca	ardiac or resp	iratory arrest,	John Spring	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		teriosc1	Lerotic	Cardiov	78 SC11 1 8	r Dica	356	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse			- dararov	ascara	I DISC	ase	
h		2	Sequentially list conditions,								
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence or):						
<u> </u>	execun and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a conse	equence of):			_			
8760	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dicail		).							
99	ng ph	Medi	IE ECNANI E.	_							
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe		Ectopic pregn	ancv			23d. Date of deli-	•
0.	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specif				Month	Day Year
<u>.</u>	w requires that the d been signed by the should be detached		Part II. Other significant conditions con	Intributing to death but not re	asulting in the un	idarhina cauc	o awaa ia Bart I	1 2	2a. Did tahasa		
ecords,	sign of be	Δ.	•		sauling in the th	idenying caus	e giveni ili raliti.	2.	1 🗌 Yes		the cause of death?
CO	w req	ompieted							-		bably 4 Dunknown
Ke	o - c o	ф				<del></del>		24	Ia. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
	icien: Th certificate rector, pag	e C	25. Was case referred to medical				26 Place of	f Death (Chec	Yes 2 N	to 1 ☐ Yes	2 No
	dis di	ToB	examiner? 1 X Yes 2 No H	ospital: 1 2 Inpatient 2	☐ER/Outpatient	3□ DOA	Other			6 ☐Other (Speci	(fv)
$\subseteq$	fter free		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		escribe how inj		
<u> </u>	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 □ Yes 2 □ No	)			
DIVISION	or Al after of Direction by	ertification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre cify)	et, factory, of	ice	28f. Lo	cation (Street a by or Town, Sta	and Number or Rur ite)	al Route Number,
	spitel ours ours reral filled	OL	29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my kn	owledge death	COOLERAD OF The	- lime data and -	alasa and du			
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	edicai	(Check only 2 Medical Examin	er: On the basis of examin and manner stated.	ation and/or inv	estigation, in a	ny opinion, death	occurred at th	e to the cause( ne time, date a	s) and manner as s nd place, and due t	o the cause(s)
	To th withir To th comp	¥	29b. Signature and title of certifier	F -		29c. Lic	ense number		29d. D	ate signed (Month,	Day, Year)
	,		) V. V.	-in o. Com	b)		D15236			April 15	, 2004
	12		30. Name and address of person who cor	npleted cause of death (Ite	om 23a) (Type, P	Print)					
			Carl Margolis, MD	11125 Rocky	ille Pk	, Rock	ville, M	D 2085	2		
	Stat Registra		31. Date filed (Month, Day, Year) APR 2 1 200	32. Registrar's Sign	nature 4	Lon	1				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician Shievel 2:45 PM eana /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kehab Carroll Westminster Nursing and Center Westminster Hours Min. 8. Date of Birth (Month, Dey, Year) Oct. 8, 1925 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days Months 1□ M 20XF 276-20-3989 78 Director Stauntón, Usual Residence of Decedent filed within 72 hours aftar deeth with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits parmit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Dapartment of Health end Mantal Hyglana. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shown any injury or other traumatic event, the Madical Exarciner must be notified at once. 1XXYes 2 □ No **Funeral Director** Carroll Manchester 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21102 United States 3214 Keating Court 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 森(X) No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White Specify: Be Completed by 3KXWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Administative Secretary Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Mary Sciranko John Stoffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3214 Keating Court, Manchester, Md. 21102 Charles B. Shiever - Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State etery, crematory or other place) 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4/20/2004 Hampstead, Md. 21074 Carroll Cremation, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Kenworthy Funeral Home, Inc. CC0354 269 Frederick Street, nanover, PA. 17331 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Physician Immediate Cause (Final diseese or condition resulting in death) /Medical conce Examiner Physician/Medical Examiner certificate has been signed by the ettending physician and lifector, paga 2 should be detached for use as the bunal-trensit or Attending Physician: The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 25 KNo 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? 1 Yas 250No 1 ☐ Yes 2 No : After this certifice e funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Naturel 2 Accident 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completaly filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Yeer) 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 307, Westminster Stone Wilby 31. Dete filed (Month, Day, Year) / APR 2 0 32. Registrar's Signature State 2004 Registrar

SHIEVER

State of Maryland / Department of Health and Mental Hygiene o Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SCHAVER **Physician** HENRY RAYMOND APRIL 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death **Examiner** HOLY CRUSS SILVER SPRING MONTGOMBR HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1⊠M 2□F Director 80 579-20-7937 June 4, 1923 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28a-1 show an once. 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road, #1112 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1943-45 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Communications 2 Management Analyst Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Charles Schauer Vera Gronly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond C. Shauer/ Son 314 Whitestone Road, Silver Spring, MD 20901 20b. Place of Disposition (Name of cometery, crematory or other place Parklawn Memorial April 17, 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation \_5 ☐ Other (Specify) 2004 Rockville, Maryland Park 21. Signature of Pineral Service Ligensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESARTION FAILURE **Physician** /Medical Examiner restrictive lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physicien: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit MASSE Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PRIOR SPLENBOTOMY FOR HEMIOLYTIC ANEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PROSUTIC HYPERTROPH 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2√ No ۲ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signa are, ind title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D36252 sen ( lun 12+1 leted cause of death (Item 23a) (Type, Print) 11501 GEORGIA HVE, STE, ST, WHOMTON MD 20902 7. KARIYA,MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 16 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Schurman April 11, 7:00 A M Joseph R. 2004 /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mitchellville Prince Georges Villa Rosa Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Min. **Funeral** Months Days Hours 1 □XM 2 □ E January New York 80 5,1924 Director 078-24-4763 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location r than "neturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Chevy Chase Completed by Funeral Director Maryland | Montgomery 10g. Citizen of Whal Country? 10f. Zip Code 10e. Street and Number USA 20815 17 Hesketh Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 ZYes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: WW-II 1 Yes 2 No Specify: Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 5+ Lawyer peril traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 90 Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injuger or other traumatic average. Mary Cushman is marked Jacob Gould Schurman, Jr. ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17 Hesketh Street, Chevy Chase, MD. 20815 Evelyn D. Schurman/Wife Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 13, 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory Alex., Va. ` 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility
DeVol Funeral Home
2222 Wisconsin Ave., NW., Wash., DC 20007 21. Signature of Funeral Service License. lemys 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Pneumonia 2 Days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year 101 in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Senile Dementia Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check on one director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☒ No 2 After this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death after death.
I Director: After the funera Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funerel [ Hospitel 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signardi and title of certific To D22780 April 12, 2004 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 7500 Greenway Center #430, Greenbelt, MD. 20770 M.D., Peter M. Schissler, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Renderma. oaks APR Registrar

			ricase	State of Maryland	d / Depa	rtment of F	lealth and	Mental Hy	giene c	2001	11.50	
		•	For State Registrar		Cer	tificate of	Death	,	Reg. No.	004	1468	1
		33	Decedent's Name (First, Middle, Last	it)				2. Date of De Month	ath Day	Yeer	3. Time of Death	
	Physici /Medic		Samuel Scolni	κ				April	7, 2	004	11:40 A	Λ
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat	h	4c. Cou	unty of Death		
Links			3700 Calvert P. 5. Social Security Number 6. S		lact highday)	Kensi	Ington	8 Date of Bi		tgomer		70
1	Funeral Director			© M 2□F 7. Age (my/s. n	Yrs.	Months Days	Hours Min.		1912	Mair	place (State or Foreig htry)	14 4
4	2 - 21		Usual Residence of Decedent					100 25	, 1712			_
	uylan thow	_	10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2X No	
	8a-f	Director		gomery K	Kensin	gton 10f. Zip Code		1	10a Citizan	of What Cour		
	with ti	ā	10e. Street and Number				•			or venac oour	idy i	
	within 72 hours after death with the Maryland ene. then "netural", or tiems 23e or 28e-f show ta Madical Examiner i mai Le mullied al	Funerai	3700 Calvert P.	12. Was Decedent Ever in U.	S. 13. \	20895 Was Decedent of F	) Hispanic Origin? (S an, Mexican, Puer	pecify Yes or N	USA 0- 14. I	Race - Americ		
ယ	or Iter	F	1 ☐ Never Married 2 ☐ Married	Amed Forces? 1 ☐Yes 2 ☐ No If Yes, Give		f Yes, specify Cub 1 □ Yes 2 → No		(o Hican, etc.)		Black, White, ecify:	etc.	
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21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest gra	fucation ide completed)	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind o	of Business/In	dustry	
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р 5	filed Hygin Sther ent,		17. Father's Name (First, Middle, Last,		ALL	orney	18. Mother's Na	me (First, Middle			200	
Maryland	should be and Mental s marked o umatic eve	To Be	Kalman Scolnik				Mary Gu	rewitz				
ary	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or litems 23e or 28a-f show aumatic event, If a Madical Examinar mate to retilified at	5	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street	and Number or R	ural Route Numb	er, City or To	wn, State, Zip	Code)	
Σ	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic as other.		Louis Scolnik/				s Dr. Wac	cabuc,		on - City or To	Ctato	
Baltimore,	10 = 10 1 = 10 1 = 10 1 = 10		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crer	sition (Name of natory or other pla						
ţi	rtant:		'4 □Donation 5 □Other (Special			non Cem	Apr S ess of FacilityHir	2004		phi, M		
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粮	Physician		Immediate Cause (Final	one cause on each line.		rrhythmia				3	Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a consequ		2211) 01111121						
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Вох	death certificate t e attending physion of for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy Il death 3 [	∃Ectopic pregnanc	:v		23d.	Date of delive	ery Day Year	
	0 0 2	sicia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of di 9☐ Unknown		Other (specify)				Month	Day real	
P.0	The law requires that the de ate has been signed by the a bage 2 should be detached to	Phy	9 Unknown  Part II. Other significant conditions		ulting in the u	nderlying cause of	ven in Part I	23e. Did	tobacco use	contribute to t	he cause of death?	
	signe b ed t	by	Hypertension	commoding to document not not	aking in the a	naony ing oddoo g.					ably 4 Unknow	m
Ö	w requir been si should	etec						24a. Wa	san 2	4b. Were auto	opsy findings availab	le
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tal		e Cc	25. Was case referred to medical				26. Place of De	1 ☐ Yes	2LXNo one	1 🗌 Yes	2 No	
<u>&gt;</u>	S S	0 0	examiner? 1 Tes 2 TNo	Hospital: 1 Inpatient 2	ER/Outpaties	nt 3 DOA Ot	har	Home 5 ₹ Res		Other (Speci	٢)	
	ng Ph ter th neral	J: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe	how injury of	ccurred		
Division	after death. Director: After	Certification;	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	206 Leasting	(Channel a and A)	lumbos os Dus	of Courts Mumbos	_
Σį	l or Ati after d Direct	E	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, tarm, st fy)	reet, factory, office			own, State)	uniber or nore	al Route Number,	
	spite ours teral		29a. Certifier 1 X Certifying P	hysician: To the best of my kno	owledge, deat	h occurred at the t	ime, date and place	e, and due to the	e cause(s) and	d manner as s	tated.	
	To the Hospital or within 24 hours aft To the Funeral Di completely filled in	edicai	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, death occ	urred at the time	, date and pla	ice, and due t	o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7:0		29c. Licen	se number		29d. Date si	igned (Month,	Day, Year)	
	/		٤. (	P. Libre	MI	) D09	470		Ap	ril 8,	2004	
	13		30. Name and address of person who				11.00	,	3.00	20005		
)			Eugene P. Libr	32. ⊇egistrar's Signa		P		kensingt	on, MD	20895		
	St Regist	ate	APR 16 20	04 Server	5	Spork						

			. For	State of Maryla	and / Depa	artment of h	lealth and	Mental Hy	giene 200	
			= State Registrar		Ce	rtificate of	Death		Reg. No.	14 14688
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De. Month	Day Yes	3. Time of Death
	/Medic		CHARLES ALLE		RD	1		APRIL	9 200	
	Examin	er	4a. Fecility Name (If not institution, give				r Location of De	ath	4c. County of D	
			611 Tschiffely So  5. Social Security Number 6. Sec	·	rs. last birthday)	If Under 1 Year	ersburg	rs. 8. Date of Birt	Montgo	
B	Funeral Director			M 2□F 89		Months Days	Hours Mi	n. 8. Date of Birt (Month, Da Feb. 13	y Yeer) 1915	Birthplece (State or Foreign Country) Georgia
	land ow		10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Madical Examitrat court be notified at	to	Md. Montgom	ery	Gaithe	rsburg				1 ☐ Yes 2 🗷 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	-
	ath wi		611 Tschiffely S	•			20878		United S	
	er deg	Funerai		12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race - A Black, W	merican Indian, Thite, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1. Mary Yes 2. □ No If Yes, Give Year or Dates: W	WII	1 ☐ Yes 2 🗷 No	Specify:		Specify:	White
9	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busine	ss/industry
215	c * 1	pie	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)		kind of work done DO NOT use retire		rorking		
7	filed withi Hygiene. other than	Completed	12	Ō	Roo	of Consul	1			ntractor
nd		Be	17. Father's Name (First, Middle, Last)	Chanband				ame (First, Middle,	•	Duah
√ S	2 should be and Mental is marked c	P	Jesse Lee  19a. Informant's Name/Relationship (Ty	Shepherd	10h Madi	na Addana (Ctana	Minni		inda er, City or Town, State	Bush
Maryland 21215-0036	permit. Peges I and 2 should be Department of Heelth and Menta important: if Item 27 is marked any injury or other traumatic evonce.		Wei Zhen Zhao / 1							rg, Md. 20878
Baltimore,	there item		20a. Method of Disposition	200	o. Place of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State
m	Pege nent o ant: #		1 2 Surial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)	lemoval mom State		Cemetery		13/04	Rockvill	e, Maryland
alt	permit. Departr importe any inju		21. Signature of Funeral Service Licens	2	22	Mame and Addre	ss of Facility Barbe	r Funeral	Home	
_	997		May with	Saules		P. O. E	30x 5038	, Laytons	ville, Md	
	Physician		23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	eath. Do not ent		ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death YEARS
4	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
è		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons		CTIVE PUL	.MONARY	DISEASE	·	YEARS
	le be executed: ysician and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):					
3760,	ate be nysici he bu	icai		d						
K 68	death certificate e attending physi of for use as the l	Physician/Medi	IF FEMALE:							7.00
Вох	attenc for us	ian/	in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnanc	/		23d. Date of Month	delivery Day Year
o.	that the de ed by the a detached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ordeaur 5	_ Other (specify) _				
<b>Q</b> .	law requires that the as been signed by the 2 should be detache	by Ph	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
rds	w requires been signi should be	q pa	PERIPHERAL VASCUI	AR DISEASE				128	res 2 □ No 3 □	Probably 4 Unknown
900	aw re	piet						24a. Was		autopsy findings available to completion of cause of
of Vital Records,	The ate h	Completed							rmed? death	? es 2□ No
/ita	ician: certifica rector. p	Be (	25. Was case referred to medical examiner?				28. Place of D	eath (Check only o	ne)	
) t	ys Gir	은	1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2		IL SEL DOA			lence 6 Other (S	pecify)
no	ding h. After fune	tion	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wo	yat k? Yes 2 ⊟No	280. Describe r	now injury occurred	
Division	ten leat tor: the	fica	3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, str			28f. Location (S	Street end Number or	Rurel Route Number,
Ö	s after al Dire	Certification:	4  Homicide determined	building, etc. (Spe	ecity)			City or Tow	m, State)	
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical		sician: To the best of my liner: On the basis of exam and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	3 11		29c. Licens			29d. Date signed (Mo	
)			1 A 20806	> ~ ((		D53	317		APRIL 9	, 2004
	(et l		30. Name and address of person who co				13. GAT	THERSBURG	, MD. 208	277
	Sta		31. Date filed (Month, Day, Year) APR 1 2 200	32. Registrar's Signature	gnature /			THENOUNG	, 110. 200	)
	Registr	ar	MLU TY 500	T Alexander		Spark				

		State of Maryland		artment of Hertificate of L			6 U	04 14689
p +-		Registrar  1. Decedent's Name (First, Middle, Last)		timouto of E		2. Date of De		3. Time of Death
Physici /Medic		THOMAS C. SHIFFL	ETT			APP.	Day 2	004 2:00PM.
Examin	100	4a. Facility Name (If not institution, give street and number)	) 1	4b. City, Town, or	Location of D	eath	4c. County of	Death 1
	* J	5. Social Security Number 6. Sex 7. Age (In yrs.)	last hirthday	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th s	Birthplace (State or Foreign
Funeral Director		224-46-7981 1X M 20 F 67	Yrs.	Months Days		Min. (Month, Da	9,1936	VIRGINIA
		Usual Residence of Decedent				DEG. 1	7,1750	
arylan ahow	_		y, Town or Lo					10d. Inside City Limits 1▼ Yes 2 No
be Ma 188-1	Director	MD. PRINCE GEORGES  10e. Street and Number		HYATTSV 10f. Zip Code	ILLE		10g. Citizen of Wh	A
with t					784			S.A.
U36  wurs after death with the Maryland rat, or items 23s or 28e-f ahow Everthet must be notified at	Funeral	5116 72nd PL.  11. Marital Status 12. Was Decedent Ever in U.	.S. 13.	Was Decedent of His If Yes, specify Cubar		? (Specify Yes or No		American Indian,
	Ē	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Married 1 ☐ Never Married 2 ☐ No If Yes, Give		ir Yes, specify Cubar 1 ☐ Yes 2 <b>X</b> No		ueno Rican, etc.)	Specify:	White, etc.
5-0036 72 hours after natural, or ite	d by	3 Widowed 4 Divorced Year or Dates: WWII						WHITE
	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of	working	16b. Kind of Busin	ness/industry
d 2121 filed within Hygiene. other than '	dwo	Elementary/Secondary (0-12) College (1-4or 5+)		JALITY CON		CR.	PEPSI	COLA CO
other (ent.	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle	, Maiden Sumame)	-
arylan should be nd Mental marked c	ToE	THOMAS C. SHIFFLETT	SR.			MAMIE	HUNT	1
Maryland d 2 should be file th and Mental Hy 7 is marked oth treumatic even		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a			•	
C 2 14 7	1	ALICE SHIFFLETT/WIFE  20a. Method of Disposition 20b. P	5116	72nd Position (Name of	L., HY	ATTSVILLE	, MD. 207 20c. Location - Ci	
0 % = 5		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	emetery, cre	matory or other place		16_2004		OOD, MD.
inite and		21. Signature of Funeral Service Ligensee		Name and Address IAMBERS FU	4 - 300			
De per per per per per per per per per pe	N I	M-M- Chambers MOOD		IAMBERS FU 301 CLEVEL				
		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	h. Do not en	ter the mode of dying	g, such as car	rdiac or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	n ch	conic 17	-ADI	aton	las-luc	Onset and Death
/Medical Examiner		Due to (or as a consequence of the consequence of t	uence of):		V	00		, 0
Examino.	*	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence)	uence of):				7	days
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	,					
8760, ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence)	uence of):					
3760 ate be e hysician the buris	lical	d						
as as as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregna	ancu.					
Box  auth cer attendin for use	lan	in the past 12 months?	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
P.O. I	yslc	1 Yes 2 No 9 Unknown						
of Vital Records, P.O Physician: The law requires that the r this cartificate has been signed by th rail director, page 2 should be detache	by Pi	Part II. Other significant conditions contributing to death but not rest	ulting in the u	inderlying cause give	n in Part I.	23e. Did 1	obacco use contrib	ute to the cause of death?
cords, w requires been sign should be	edt	Enthonany Jobrosis	Ch	rouse 0	bin	retire 18	Yes 2□No 3	☐ Probably 4 ☐Unknown
Records, The law requires to the has been signed age 2 should be to	Completed	pulmon any disease,	sey	250		24a. Was	psy prid	re autopsy findings available or to completion of cause of
The The cate h	Con		/			perfo 1 ☐ Yes		ath? ] Yes 2⊠ No
Vital Filorian: The certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:		ot 30 DOA Cthe	AP.	Death (Check only		
on of ding Phys	.: To	1 res 25 No 12 Supatient 2	28b. Time o	" 30 00A	4 🗆 1401311	ng Home 5 Resi	how injury occurred	
ion nding tth. r: Afte e fune	atlor	1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		:? ∕es 2 □ No			
Division of Vital  of Attending Physician: after death. Director: After this certifical in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ht building, etc. (Specific Specific	ome, farm, st	reet, factory, office		28f. Location ( City or To		or Rural Route Number,
itel o	Ç							
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his -completely filled in by the funeral director, page	ledical	29a. Certifier (Check only one) 12 Certifying Physician: To the basis of my kno 2 Medical Examiner: On the basis of examina and manner stated						
o the ithin 2 o the omple	Me	29b. Signajure and title of certifier		29c. License	number		29d. Date signed (	Month, Dey, Year)
( x)		MS, MD, FCCP		D 3	6845	5	April	13,2004
~[		30. Name and address of person who completed cause of death (Item	п 23а) (Туре,	Print) MAI-	-CHI	NGUT	PEN, a	D, FECP
		7350 grace Inve	Cot	umbora	1	40 2	1044	
St Regist	ate rar	31. Date filed (Month, Day, Year)  APR 15 2004  32. Registrar's Signa	State State	Sporks	1		·	

			For State	State of Maryland / Depa	rtment of Health	and Mental Hy		14690
			RegistrarAMFND TTFM #10d8     Decedent's Name (First, Middle, Last)	18 PFR INF 0831 5/18/64	inspare or boar.	E. Dato of D.		3. Time of Death
	Physicia /Medic		Joy Marion Shorten			Month April	12, 2004	2:15pm M
)	Examin		4a. Facility Name (If not institution, give st	treet and number)	4b. City, Town, or Location	of Death	4c. County of Dea	ath
			Casey House  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Rockville If Under 1 Year   If Under	er 24 Hrs. 8. Date of Bi	Montgome	ery rthplace (State or Foreign
П	Funeral Director			M 2 🖾 F 78 Yrs.	Months Days Hours	Min. (Month, Di	ay, Year) C	ountry) nnsylvania
	D		Usual Residence of Decedent	10c. City, Town or Lo	oction			10d. Inside City Limits
	show	Į,	10a. State 10b. County	Caitharah				TEY'es XV No
	the A	Directo	Maryland   Montgomer  10e. Street and Number	y Gaithersbu	10f. Zip Code		10g. Citizen of What C	
	h with	iO le	16405 Henry Drive		20877		United Star	tes
	ema Ser mu	Funeral		Armed Forces?	Was Decedent of Hispanic C f Yes, specify Cuban, Mexic	Origin? (Specify Yes or Nan, Puerto Rican, etc.)	0- 14. Race - Am Black, Wh	
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 😿 No If Yes, Give Year or Dates:	1 ☐ Yes 2 【X No Specif	'y:	Specify:	nite
21215-0036	within 72 hours after death with the Maryland ene. than 'naturat', or Itema 23a or 28a-f show ite M. vifeal Examiner must be mallised at		15. Decedent's Educ	ation 16a. Deced	dent's Usual Occupation	not of working	16b. Kind of Busines	
215	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during me DO NOT use retired)	ost of working		
2	ited will have the her the	Cor	17. Father's Name (First, Middle, Last)	5+ Teac		her's Name (First, Middle	Education  Maiden Sumame)	n
anc	d ba fi	To Be	Frederick J. Shor	ten JOHN STORM		Lillian Hebe		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 la marked other than "naturat", or Itema 23a or 28a-f show many injury or other traumatic event, the Marical Examiner must be nutified at ance.	F	19a. Informant's Name/Relationship (Typ	Grant Distant	ng Address (Street and Num			Zip Code)
Σ,	and 2 ealth a m 27 I				Runkles Road	, Mt. Airy,		Town Chat
Baltimore,	or off		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Re	emoval from State	natory or other place)		20c. Location - City o	
<u>#</u>	artmar artmar ortant injury		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>	Fairview	. Name and Address of Fac	bliv DeVol Fur		Pennsylvania
Ba	Depri Impo		Chert Of G	1 1	O East Deer laithersburg,	Park Drive MD 20877		
	rij.		23a. Pan 1. Enter the disease, or complice shock, or heart failure. List only on	cations hat caused the death. Do not ent	er the mode of dying, such a	as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Pancreatic Cancer				Months
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	C. Carlotte	Jer	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying	Dua to (or as a consequence of):				
	icuted nd transit	Examiner	that initiated events					
8760,	icate be axecuted physician and the buriat-transit		resulting in death) Last	Due to (or as a consequence of):				
687	ficate g physics ts the	Physiclan/Medical	0					
Вох	death certific e attending p id for use as i	M/us	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		23d. Date of d Month	elivery Day Year
ю. В	0 0	sicl	in the past 12 months? 1 □ Yes 2 ☎ No 9 □ Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		WORTH	ouy rou
Ω.	requires that the een signed by th nould be detache			tributing to death but not resulting in the u	nderlying cause given in Pai	rt I. 23e. Did	tobacco use contribute	to the cause of death?
rds,	quires n sign uld be	ed by				1 🗆	Yes 2□No 3□f	Probably 4∰Unknown
Vital Record	aw 1sb	ompleted				24a. Wa	opsy prior to	autopsy findings available completion of cause of
Ä	The ate h page	Com				peri 1 ☐ Yes	formed?   death?	s 2⊠ No
Vita	Phyalcian: this certifica al director, p	Be	25. Was case referred to medical examiner?	ospital:		ace of Death (Check only  Nursing Home 5 \subseteq Res	SUPPLY THE REPORT OF THE PARTY	Hoopice
of		n: To	1 ☐ Yes 2 🛣 No  27. Manner of Death	2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) Injury			how injury occurred	ecily) HOSPICE
ion		atlo	1 Natural 5 Pending investigation	(Month, Day Year) Injury	M 1 ☐ Yes 2	□No		
Division		ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office		(Street and Number or I own, State)	Rural Route Number,
	ppita ours ieral	O	29a. Certifier 1X Certifying Phys	sicien: To the best of my knowledge, deat	h occurred at the time, date	and place, and due to the	e cause(s) and manner	as stated.
	Hoy Fur Ho	edical	(Check only 2 Medical Examination one)	ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, d	eath occurred at the time	o, date and place, and do	ue to the cause(s)
q	To the within 2 To the complet	Σ	29b. Signature and little of dertifier		29c. License numbe		29d. Date signed (Mor	
	10			replaced course of death (how con) (7	D35635		April 13, 2	2004
	. 1			empleted cause of death (Item 23a) (Type, 6001 Muncaster Mill		ille. MD 208	855	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sporks	,		
	Regist	rar	APR 1 5 200	4 Denov	popular			

			1 - State Registrar	State of	Marylan		artment of F rtificate of I		Mental Hy	giene Reg. <b>N</b> o		14691
	Physici /Medic		Decedent's Name (First, Middle, La Nancy Moncure	Ralls	Hille	Sout	hworth		2. Date of Domestin April	Da 13		3. Time of Death 0600A M
	Examir Funeral	er		e Nursi			4b. City, Town, or Silver Silver Months Days	Spring	S. 8. Date of Bi	rth	County of Deadle County	ery thplace (State or Foreign ountry)
	Director wods	٥٢	Usuat Residence of Decedent  10a. State 10b. County			ty, Town or Lo	ocation		Oct. 9	, 19	22  Was	nington, D.C  10d. Inside City Limits  1 □ Yes 2 ▼ No
	permit. Pagas 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiena. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show minioury or other traumatic event, the Medical Examinat must be muitified at ances.	Funeral Director	Maryland   Montgom 10e. Street and Number 2535 LittleVesta		Si	lver S	pring 10f. Zip Code 208	332		_	tizen of What Co	ountry?
980	ours attar dei rel', or Itams Examiner n	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2 🔯 No e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	lispanic Origin? ( an, Mexican, Pue Specify:	(Specify Yes or No arto Rican, etc.)	0-	14. Race - Ame Black, White Specify:	
21215-0036	d within 72 ho jiena. r than "natu the Modical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12		-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired istrative	during most of w d)	•		and of Business	/Industry
yland ;	iould ba filed v I Mental Hygie varkad other i natic event, tr	To Be C		Milton	R	alls		Nannie			Stone	
re, Mar	s 1 and 2 sh if Health and itam 27 Is m other traum		19a. Informant's Name/Relationship ( Gayle Southworth  20a. Method of Disposition	Rickert	20b. F	er 1 So	ng Address (Street: nata Cour osition (Name of matory or other place	t., Sil	ver Spri	ng,	or Town, State, MD 209 ocation - City or	01
Baltimore, Maryland	permit. Paga Department of Importent: If eny injury or once.		1 ☐ Burial 2 ☒ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	fy)	State Ch	esapea	ke Cremat 2. Name and Addres app Funer 33 Gist A	ory Apri			tsville	
	Physician /Medical Examiner	16	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Coro	onary or as a conseq	Artery Artery Quence of): Aorti	er the mode of dyin  Disease  c Aneurys	g, such as cardi	IIVET Sp	ring urrest,	, MD 20	Approximate Interval Between Onset and Death 4 months
58760,	icate ba exacuted physician and s the burial-transit	dical Examiner	and the leaders to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c.	or as a conseq							Quantity of the systems to
.O. Box (	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown		rth 2 ∏ Feta ant at time of d	ıl death 3 [	Ectopic pregnancy Other (specify)				23d. Date of de Month	ivery Day Year
ords, P	w requires that been signad t should be dela	by	Part II. Other significant conditions Osteomyelitis	contributing to de	ath but not res	ulting in the u	nderlying cause give	en in Part I.				the cause of death?
al Records,	n: The law raicate has be	Completed	Cerebrovascula	r Accide	ent			<u> </u>	1 ☐ Yes	psy ormed? 2 1 No	prior to death?	itopsy findings available completion of cause of 21 No
Division of Vital	Attending Physicien: The Ir death. sctor: Atter this certilicate has etter this certilicate hay the tuneral director, page	atlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Naturat 5 Pending investigation	28a. Date o (Monti	npatient 2 🗆 of Injury h, Day Year)	ER/Outpatier 28b. Time of tnjury	28c. Injun Worl	er: 4X Nursing	eath (Check only Home 5 Resi 28d. Describe	dence		city)
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	To the Hospital or Attent within 24 hours after death To the Funerel Diractor: completely filled in by the	Medical	29a. Certifier 1 ★ Certifying P (Check only 2 ★ Medical Exa one)  29b. Signature and title of certifier	hysician: To the miner: On the ba and mann	sis of examina	ation and/or in	n occurred at the tim vestigation, in my or 29c. License	pinion, death occ	ce, and due to the curred at the time,	date and	) and manner as d place, and due te signed (Mont	to the cause(s)
	5		30. Name and address of person who	completed cause		M D n 23a) (Type,	D595	24			ril 13,	
	Sta	ite	Loveen Puthumana 31. Date filed (Month, Day, Year)	32. R	gistrar's Signa		Lead Road		Spring,	MD	20904	
	Registi	ar	APR 15 2	004	eneral	P	pporks					

NANCY SOLIHWORLY DOD/64-13-07 TOD/0600

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Physician 12, 1:45  $a^{M}$ April Sidney Delano Staples 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice- Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31, 1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Days Hours 69 Minnesota Director 447-32-6627 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 1900 Lyttonsville Road, Unit 919 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Korean Year or Dates: Conflict hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed filed within 72 h I Hygiene. other than \*natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Consultant Restaurant permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important: If fem 27 is marked other ti
any niury or other traumatic event, In other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewellyn Staples Petriche Derr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 1900 Lyttonsville Road, Unit 919, Silver Spring, MD Nancy Staples/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Veteran Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Brodles 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failtre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or comition resulting in death) Priysician Renal Failure Week /Medical Due to (or as a consequence of): **Examiner** Renal Cell Carcinoma Z Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts. Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of) ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:  $_{4\ \square\ \text{Nursing Home}}$  5  $\square\ \text{Residence}$  6  $\square\ \text{Other}\ (\textit{Specify}) \\ \text{Hospice}$ 1 ☐ Yes \_ 2 X No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital or To the Hospital a within 24 hours at To the Funeral D 29a. Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09470 April 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10400 Connecticut Avenue, Eugene P. Libre M.D. Kensington, MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2004 oaks Registrar

State of Maryland / Department of Health and Mental Hygiene 00 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Patricia Louise Strosnider 11, 2004 April 1:03 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01nev Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 4, 1925 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 78 577-32-6760 Nebraska Director Usual Residence of Deceden death with the Maryland nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan bartment of Health and Mental Hygiene.

ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury goother traumatic avent. Ite Mortal Examined in the molified at 18a-6. 10a, State 10b, County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 N. Leisure World Blvd., #1010 20906 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Businesswoman Hardware 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John H. Hansen Frances J. Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Sharon A. Gran / Daughter 7237 Deer Lake Lane, Derwood, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 ☑Other (Specify) Entombment Gate of Heaven Cemetery April 16, 2004 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home In 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 cento 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bronchiolitis Obliterans Organizing Pneumonia /Medical **Examiner** Aspergillus Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Hypertension, Pre-Renal Azotemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 X No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 4 - Homicide City or Town, State. within 24 hours a t 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11x TANgro D53317 April 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Ball M.D. 16225 Frederick Road, #213, Gaithersburg, MD 20877 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **APR 14** Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12, 2004 April 0:55 p F. Sullivan Marian /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Garrett Park Montgomery 10906 Kenilworth Ave. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. 1 ☐ M 2 🖾 F Sept. 6, 1926 Washington D.C. 577-38-5893 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 🙀 No MD. Montgomery Garrett Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20896 10906 Kenilworth Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elijah Smead Alvord Gladys Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Flanders/son 4504 Clermont Pl., Garrett Park, Md. 20896 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Comfort Crematory 4/15/2004 Alexandria, Va. 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisc. Ave., NW., Washington D.C. 20016 E 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 2 Yrs. Carcinoma of Head and Neck resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a ponsequence of: Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Detail death 3 Ectopic pregnancy 1 Live hirth Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☑No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 1 Tyes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27 Manner of Death Certification: 5 Pending 1 KNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 14, 2004 D23308 Mar Pringomo 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Victor M. Priego, M.D. 6420 Rockledge Dr., Suite 4100 Bethesda, MD 20817 31. Date filed (Month, Day, Year) APR 1 6 2004 32. Registrar's Signature State oaks

Registrar DHMH 17 Rev 1/2001

**Funeral** 

Director

or 28a-f show

item 27 le marked other than "naturel", or items 23a or 28a-f shov other traumatic event, it a Midical Examinar must be notified at

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or Attending Physician:

To the Hospital

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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Baltimore, Maryland 21215-0036

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death 1

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		_	State Registrar		Cei	tificat	e of Dea	ith	Re	g. No.		
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ş	/Medic	al .	4a. Facility Name (If not institution, give	Street and number)		4h City	Town, or Locati	ion of Death	04	4c. County of	Deeth 1750	
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	Funeral		Social Security Number 6. S		ast birthday)	If Unde Months	r 1 Year   If Un	nder 24 Hrs.	8. Date of Birth (Month, Day,	Year)	Birthplece (State or Ford Country)	eign
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	pur *	}	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Lin	nits
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	eme S	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dece	dent of Hispanic city Cuban, Mex	c Origin? (Spe xican, Puerto	cify Yes or No- Rican, etc.)		American Indian, White, etc.	
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1215-0036	hour		15. Decedent's Edu		16a. Dece	dent's Usu	al Occupation			16b. Kind of Busi	iness/Industry	
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<u> </u>	be filed within 72 hours after death with the Marylan Hygiene.  de Hygiene.  de other than "natural", or flems 23a or 28a-f show event, I'rs Medical Exercitive inval to rediffed at event, I'rs Medical Exercitive inval to rediffed at	Be	17. Father's Name (First, Middle, Last)  Raymond Simmons	•				fother's Name Grace F		faiden Sumame)	)	
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Maryland	permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natura any injury or other traumatic event, It a Medical Egince.		19a. Informant's Name/Relationship (Ty Charles Sadler/h	iusband					old, MD	21012	are, zip oode)	
<u>က်</u>	Heal Heal tem 2		20a. Method of Disposition	20b. P	lace of Dispo emetery, crei	sition (Na	me of	0	ate	20c. Location - C	ity or Town, State	
Ē	Pages ent of nt: If I		1 ☐ Burial 2 ② Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)		timore			4/22/	2004	Baltimor	re, MD	
Baltimore,	partm ports y inju		21. Signatura de l'uneral Service Licens	88 9-11	22	2. Name a	nd Address of F	acility Joh	n M. Ta	ylor Fur	neral Home	
m —	88 3 5 8		Todd	C. are			uke of C				MD 21401	
-15			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the deat ne cause on each line.	h. Do not ent	er the mo	de of dying, such	h as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death	
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	/Medical Examiner		1930king in dodain)	Due to (or as a conseq	uence of):							1
Ž		er	Sequentially list conditions,	b. Due to (or as a conseq	uanca of):							
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	To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner stated.		29	c. License numi	ber	29	9d. Date signed	(Month, Day, Year)	
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			30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type,	Print)					17,2004 uns 2140	
2			Michael FRE	Esulu 116			Highma	y A	Maylous	Mary	ms 2140	1
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Signa	ature	1-		/	• /	/		

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April Julia A. Schiller 5:55 2004  $A^{M}$ /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis Eldercare, Spa Creek Center Annapotto

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.
Nov. 9, 15 Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** 1 □ M 21 F 579-22-3543 92 Director 1911 New York Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar must be rediffed at Maryland Anne Arundel Annapolis 1 ☐ Yes 2\ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 East Lake Drive 21403 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Yes 2000 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 Yes XXNo Specify Specify: White 3XXWidowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 PBX Operator Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Cregon Annie Mahon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Varson/daughter 28 East Lake Drive Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Baltimore Crematory 4/14/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Fervice License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic Obstructus Poluman Directe Immediate Cause (Final Physician 6M disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of). the attending physician Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) P.O. I 1 Yes 2 No detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. s after death. investigation M 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of certile 29c. License number 29d. Date signed (Month, Day, Year) 737036 Drumms 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/18 D. Donah Drive Charles, MI) COV Dro 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State 3 2004 Registrar

Milton Sollers 04-2501 DOS

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

OS			1 = For State Registrar		epartment of Health and Certificate of Death		/ III la	14697
			Decedent's Name (First, Middle, Last,		perimente er beaur	2. Date of Death		3. Time of Death
	Physici /Medio		Milton	Sollers		April 12	Day Year 2. 2004	621 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Death	021 4
			Fort Washington	Hospital	Fort Washingt		Prince Ge	eorges
	Funeral		5. Social Security Number 6. Security Number	YM 2□E	Months Days Hours Mir	1. (Month, Day, Ye	9. Birthpl Count	ace (State or Foreign try)
	Director		218-12-9308 Usual Residence of Decedent	82 Yr	5.	Sept. 7	1921 Mar	yland
	yland Iow		10a. State 10b. County	10c. City, Town	or Location		10	Od. Inside City Limits
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	or 28	Director	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Coun	try?
	23a	at	1201 Marlboro	Road	20711		USA	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li> </ol>	Specify Yes or No- into Rican, etc.)	14. Race - America Black, White, e	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 Ho Specify:		Specify: Bla	ck
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene.  dother than "natural", or Itams 23s or 28s-f ehow event, the Medical Examinar mala be notified at	ed	15. Decedent's Edu	cation 16a. D	ecedent's Usual Occupation	168	b. Kind of Business/Ind	
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nd	tal Hy	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Mai	den Sumame)	
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Maryland	- a - a		19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Number or F			,
	is 1 and 2 if Health Item 27 I		Mary Sollers (W 20a. Method of Disposition	20b. Place of D	11 Marlboro Rd.		Marviand Location - City or Tov	
JOL	0 0		1X Burial 2 ☐ Cremation 3 ☐ F  ' 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State Mococ	Cemetery 4/	17/04	Drury, Md	
Baltimore,	arth orte		21. Signature of Funeral Service Licens		22. Name and Address of Facility			
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			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not not cause on each line.				Approximate Interval Between
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95	/Medical Examiner		resulting in death)	Due to (or as a consequence of)	:			
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	To the Hospitel or within 24 hours after the Funeral Discompletely filled in	Medical (	29a. Certifier 1 Certifying Physic (Check only one)	sician: To the best of my knowledge, oner: On the basis of examination and/of and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occ	e, and due to the cause	e(s) and manner as sta	ted. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and manufacture.	29c. License number	29d.	Date signed (Month, D	ay, Year)
	F > F 0		I hig hi.	m.D	OCME		April 13,	2004
			30. Name and address of person who co	empleted cause of death (Item 23a) (Ty	pe, Print)			
) ===				m.D	111 Penn Stree	et, Baltimo	ore, Maryla	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 5 2	32. Redistrar's Signature	South)			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Natalie A. Shea Apr. 9, 1747 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 041-01-7111 84 Director May 4, Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Anne Arundel Arnold 1 ☐ Yes 2X No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1263 Seminole Drive 21012 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify. Specify þ 3 AWidowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. homemaker Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) 12 should be fi h and Mental H 7 is marked ot Joseph Jutinskas Alexandria Danilaiciute 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train Diane S. Bragdon/Daughter 1416 Bayhead Road, Annapolis, MD 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ital 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Apr. 12, 2004 Davidsonville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial 21. Signature of Funeral Service Licenses Barrancod & Sons, P.A. Severna Park Funeral Home 'n Momy 7h 495 Gov. ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** entusin /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or rigury that initiated events resulting in death) Last Due to or as a consequence of) Examiner and I-transit death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f o. 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Naturai s after de... 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License numbei 29d. Date signed (Month, Day, Year) D 28686 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Highway Arnold MOZIOIZ Victor M. Planner 1509 Ritchie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician JAMES** DICKERMAN SMALL APR 2004 16 6:48 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year, Oct. 27, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 84 1919 New York Director 128-07-5367 Usuel Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hyglene.
ant: If tiem 27 is marked other than "natural", or itema 23a or 28a-1 show ury or other fraumatic event, the Medical Estatular man be notified. 1 Yes 2 No Virginia Fairfax Alexandria Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8318 Ashwood Drive 22308 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Amed Folloss: 1 Gyes 2 No If Yes, Give Year or Dates: Career 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Naval Officer U.S. Navy 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Arner Small Lois Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Small/wife 8318 Ashwood Drive Alexandria, Virginia 22308 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of F important: If its any injury or oth 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory 4/21/2004 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Sprvice Licensee todal 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final disease or condition **Physician** NON SMALL CELL LUNG CANCER resulting in death) /Medical Due to (or as e consequence of): **Examiner** Sequentially list conditions, Due to (or as a sunsequence of) Examiner any, reading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical phys IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 x Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) à 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, feath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stajed. 29a. Certifier Medical (Check only one) in a 29c. License number 29d. Date sighed (Month, Day, Year) 29b. Signature and title of certifier Tol 09 0102201465 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER TODD R. LAROCK LCDR MC USN BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 32. Red State APR 2 0 2004 Registrar

**ORIGINAL** 

### VOID

# CERTIFICATE #

2004-14700

## SEE

**CERTIFICATE #** 

2004-19595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Wladyslaw Szlendak  $P^{M}$ 2004 March 30. 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 23087 Marshall Road St. Mary's Lexington Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Yrs. February 28, 1923 Poland 216-34-8326 81 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No St. Mary's Lexington Park Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23087 Marshall Road 20653 death \ Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White δ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed The Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) uith and Mental Hygiene. 27 is marked other than "r ir traumatic svent, the Med Elementary/Secondary (0-12) College (1-4or 5+) College Special Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 90 Karol Szlendak Jozefa Peda Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If itsm 27 is or other tra 23087 Marshall Road, Lexington Park, Maryland 20653 Stanislawa Szlendak/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 5, 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Once. 4 □ Donation 5 □ Other (Specify) 2004 Leonardtown, Maryland Charles Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAYS **Physician** /Medical Examiner ONMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): physician attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown s been signed be should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed FAILVAC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 2□ No 1□ Yes 2₽No 1 Tyes Attending Physician: rector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗆 Yes 2 No funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation the 2 Accident within 24 hours after deat To the Funerei Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital l 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D56096 4.1.04

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

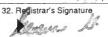
Division of Vital Records,

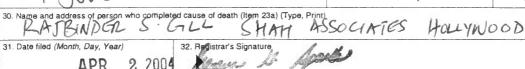
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

2004





MD

		For State Registrar	State of Maryland /	Depa Cer	artment rtificate	of H	ealth a Death	and M		giene Reg. No.	200	14	147	02
Physici	an	Decedent's Name (First, Middle, Last)							2. Date of De. Month	Day	,	/ear	3. Time of D	14
/Media	cal	Harry Bernard Sw  4a. Facility Neme (If not institution, give s			4b. City, To	own, or	Location of	f Death	April	3 4c.	20( County of		8:00	Р "
Examir	ier	St. Mary's Nursin			Leona					l l	. Ma		1	
Funeral Director	12.0	220-38-4920	M 2 F 7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Months	Year Days	If Under: Hours	Min.	8. Date of Bird (Month, Da June 28	y, Year)	21		lace (State or lary) Land	Foreign
the Maryland 28a-f show	rector	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Mary  10e. Street and Number	10c. City, To			Code				10g. Citiz	en of Wh		0d. Inside City 1 Tes 2	
3a or		21490 Hunters Retr	eat Lane		206					USA				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene.  Department of Heatin and Mental Hygiene.  Department if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, I'ra Medical Examinar must be notified at once.	by Funeral Directo		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:		Was Decede		spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 1	Black, Specify:	Amend White,		
thin 72 hore.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		ia. Deced (Give life.	dent's Usual kind of work DO NOT use	Occupa done d retired)	tion uring most	of worki	ng	16b. Kir	nd of Busi	iness/Ind	dustry	
led will ygien har th		1st		Bus	s Boy		10 11-15-		(Final Baidalla		taur			
ould be fill Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last)  Benjamin Gorman S					Ani	ta G	(First, Middle, uyther					
1 and 2 sh Health and om 27 is m		19a. Informant's Name/Relationship (Ty)  Carolyn S. Drury/ 20a. Method of Disposition	Sister 2	21490	Hunt	ers	Retr	eat	Lane L	eona	rdto	wn,		50
Pages 1 nent of thint: If ite		1 ■ Burial 2 Cremation 3 R	emoval from State		osition (Name matory or oth	er place			/2004					rd
permit. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify)  21. Signature if Funeral Service License		22	2. Name and		s of Facilit	y Bri	nsfield d, Leon	Fun	eral	Hon	e, P.A	
19.000		23a. Part1. Enter the disease, of Camilli shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death. De cause on each line.	o not ent	ter the mode	of dying	, such as	cardiac o	r respiratory ai	rest,			Approximate Interval Betwee On-et and De	een .
Physician /Medical Examiner		disease or condition resulting in death)	Due to (or s a con let uenc	Tar	To H	MA	un	i e	<u> </u>			t	lai	1
uted Insit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):	7 1/	700	707 11						1	/
certificate be executed ording physician and use as the burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or as a consequenc	e of):									es per	
death certific e attending p	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic preg					2	3d. Date Montl		*	ear
requires that the	by	Part II. Other significant conditions con	tributing to death but not resulting	j in the u	nderlying cau	use give	n in Part I.			obacco us			e cause of dea	
The far ate has page 2	Completed								24a. Was autop perfo 1 □ Yes		pri de	or to cor ath?	psy findings av	variable use of
Physician: The this certificate	o Be	25. Was case referred to medical examiner?	ospital:	Quan - :		Othe			(Check only o		По:	(0		
ng Ph fter th	<b>j</b> —	1 Yes 2 No  27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  2 □ ER/0 28b	Dutpatier  Time of Injury		c. Injury Work	at at		ne 5 ☐ Resid 28d. Describe h				()	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Sertification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str					28f. Location (5 City or Tox		l Number	or Rura	l Route Numbe	e <i>r</i> ,
To the Hospits within 24 hours To the Funera completely fille	edical C	29a. Certifier 1	sician: To the best of my knowled ner: On the basis of examination and manner stated.	ige, death and/or in	h occurred at vestigation, in	t the tim	e, date an	d place, a	and due to the ed at the time,	cause(s) date and	and manr place, an	ner as st d due to	ated. the cause(s)	
To the comp	W	29b. Signature and title of certifier	1 Jarbos	M	29c.	License	number 06	tic	7	29d. Date	signed (	Month,	Day, Year)	
3			Road Hollywoo			nd 2	20636	Jai	mes P.	Jarb	oe, l	MD		
Sta Regist	ate rar	31. Date filed (Month, Pay, Year)	32 Aegistrar's Signature	8	A son	30								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 14703 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9 6:00 AM Ronald Lee Stauffer April 2004 /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 25850 Loveville Road Mechanicsville St. Mary's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthptace (State or Foreign Country) Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) **Funeral** 1X M 2 ☐ F January 14, 1997 Director N/A Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Mechanicsville Directo Maryland St. Mary's 10e. Street and Number 10g. Citizen of What Country? 20659 25850 Loveville Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Student School permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked otherny injury or other traumatic event, 9068. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Martha Ann Zimmerman Douglas Wade Stauffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25850 Loveville Road Mechanicsville, MD 20659 Douglas Wade Stauffer/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loveville Mennonite Cemetery April 13, 2004 Loveville, Maryland \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Service Licensee Michael? Hardener 23a. Part1. Enter the disea 1, or complications that caus 1, shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 1 Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ 1/0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number #0055751 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt 2050 Wildewood Center California, Maryland 20619 31. Date filed (Month Day 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:15 a.m. Hilda 2004 Catherine Smith <u> April</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Bradford Oaks Nursing Home Clinton
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2₩F Yrs July 11,1914 89 Maryland Director 154-05-5038 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No rector Maryland Prince George's Clinton 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ō 7702 Foxhall Road 20735 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify Completed by 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Aide Health 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Logan Hopewell Sadie Jennifer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7702 Foxhall Road, Clinton, Maryland 20735 Cynthia Campbell-Young/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State St. Peter Claver 4-13-2004 \* 4 ☐ Donation , 5 ☐ Other (Specify) Ridge, Maryland 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Many Cutto II 70 M01114 | 22955 H011vwood Road, Leonard Salar Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. I ist on the cause on each line. 22955 Hollywood Road, Leonardtown, MD 20650-0279 Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner DY Sequentially list conditions, 1 and 1 and 1 and 1 and 1 and 1 accuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 KNo 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D00587 50 30. Name and address of person who completed of use f death (Item 23a) (Type, Print) #101 VING-STON 32. Registrar's Signature State **APR 15** 

DHMH 17 Rev 1/2001

Registrar

2004

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 12, 2004 5:10 p.m. Joseph Andrew Saulen April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Great Mills 22118 Clipper Drive St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F Yrs. Director 018-22-1748 74 Nov.23,1929 Massachusetts Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b Counts r than "naturs!", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland St. Mary's Great Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22118 Clipper Drive 20634 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 leg Yes 2 \( \text{No}\) 1947—
If Yes, Give
Year or Dates: 1967 permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natursl", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Satellite Tracker US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Andrew Saulen Antoinette Kimokas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22040 Caravel Court, Great Mills, Maryland 20634 <u>Teresa A. Saulen / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 4-19-2004 Cheltenham, Maryland any Injury Maryland Veterans 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Fungual Service Licensee ponc Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Me Malighant **Physician** anoma resulting in death) /Medical Due to (dr as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ō in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 2 No 3 Probably 4 □Unknown 1 Yes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this funeral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours a (s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO055751 700 30. Name and aggress of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O., 23415 Three Notch Road, California, Maryland 20619 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 15 2004

			1 - For State Ragistrar		larylan		artment of tificate o			ntal Hygien		14706
H	Physici /Medic		<ol> <li>Decedent's Name (First, Middle, La Vivian Jeanette</li> </ol>	•						Date of Death Month D pril 20,	2004 Year	3. Time of Death 5:15 A M
7	Examin		4a. Fecility Name (If not institution, giv	e street and number	")		4b. City, Town	, or Location o	of Death	4	c. County of Deeth	
П			Bayside Care Cent	er				ton Par			St. Man	ry's
Cor	Funeral Director		230-36-7972	6ex 7. A □ M 2 🔏 F	ge (In yrs. 73	last birthday) Yrs.	If Under 1 Ye Months Day		Min.	Date of Birth (Month, Day, Yea ne 22, 193	9. Birth Cou Vir §	place (State or Foreign ntry) ginia
	pu &		Usuel Residence of Decedent  10a. State 10b. County		10c Cib	, Town or Lo	cation					10d. Inside City Limits
	Maryla a-f sho	tor	Maryland St. Mar	y's	700.00		exingto	n Park				1 ☐ Yes 2 X No
	with the	Funeral Director	10e. Street and Number 20915 Great Mills	Road			10f. Zip Code	2065	5.2	10g. C	itizen of What Cou	intry?
	ns 23	eral	11. Marital Status	12. Was Decedent	t Ever in U.	S. 13. V	Was Decedent of			Yes or No-	14. Race - Ameri	
36	J within 72 hours after death with the Maryland Jidon. Than "natural", or Items 23a or 28a-f show Ite Medical Exammer must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed Forces  1  Yes 2 X  If Yes, Give Year or Dates:	? <b>[</b> No		Was Decedent of f Yes, specify C 1 ☐ Yes 2 🛣 N		, Puerto Rica	an, etc.)	Black, White	
Ş	2 hou	ed	15. Decedent's E	ducation		16a. Deced	dent's Usual Occ	cupation		16b.	Kind of Business/Ir	ndustry
21215-0036	rithin 72 ne. hen "ne	Completed	(Specify only highest graves and selementary/Secondary (0-12)	college (1-4or	5+)	(Give life. L	kind of work dor DO NOT use ret	n <i>e duri</i> ng most ired)	t of working			·
2	filed w Hygier other th		1 Z 17. Father's Name (First, Middle, Last,	1			Teach		da Nama /Fi	rst, Middle, Maide	Educat	:ion
Maryland	late of the control	To Be	Roy Edward Dye					]	Ida Be	11 Dye		
Mar	C/ G = Q		19a. Informant's Name/Relationship ( Jackie Dyson/Daug				_				Park, MI	
စ်	tand Health tsm 27		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of	. ( )	Date	20c.	Location - City or T	
Baltimore,	mit. Pages partment of sortant: If its rinjury or o		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		B !		n Cremato	[A]	pril 21 <sub>:</sub> 2004	Alex	kandria, Vi	rginia
Balt	permit. Departimport sny inj		21. Signature of Funeral Service Licer	nem _		Ma	Name and Add ttingley- . Box 270	Gardiner	Funera	1 Home, P. D 20650	Α.	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the deeth							Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Chronical Due to (or as	ui f	Obstruence of):	ther f	Ulmon	De	earl w	the Hyan	Onset and Death
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,160,	death certificate be executed e attending physician and id for use as the buriat-transit	cal Exa	resulting in death) Last	Due to (or as	s a consequ	uence of):						
R9	ntifica ng ph as th	Jed	IF FEMALE:	77.1								
O. Box	it the death certifica by the attending ph tached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 10 10 10 10 10 10 10 10 10 10 10 10 1	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnal Other (specify)				23d. Date of deliv Month	ery Day Year
٦.	that the by the by detact	'Ph	Part II. Other significant conditions of	contributing to death	but not resi	ulting in the ur	nderlying cause	given in Part I.		23e. Did tobacco	use contribute to t	he cause of death?
<b>Records</b> ,	The law requires that the te has been signed by the age 2 should be detache	ed by								15 Yes	2 □ No 3 □ Prof	bably 4 Unknown
ဝင္ပ	law re as bee 2 sho	Completed								24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
_		Con								performed?	death?	2
Vital	Physician: this certific	Be (	25. Was case referred to medical examiner?					26. Place	of Death (Cr	heck only one)		
<b>—</b>	A SE	10	1 ☐ Yes 2 ☐ Me	Hospital: 1 ☐ Inpat	tient 2 🗆	ER/Outpatien	t 3 DOA	Other: 4 Nur	rsing Home	5 Residence	6 Other (Specia	(y)
ono	ath. r: After thi		27. Manner of eath  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Date)	jury ay Year)	28b. Time of Injury	_ V	ijurya# Vork? □Yes 2□1		Describe how inju	ury occurred	
Division	To the Hospital or Attending Pl within 24 hours atter death. To the Funeral Director: After to completely filled in by the funera	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of Ir	njury - At ho etc. <i>(Specif</i> )	me, fam, stre	eet, factory, office	e	28f.	Location (Street a City or Town, Sta	and Number or Run te)	al Route Number,
	se Hospit 24 hour 3e Funera 3eletely fill	Medical (	29a. Certifier (Check only 2 Medical Exer	nysicien: To the bes niner: On the basis and manner s	of examinat	wledge, death tion and/or inv	occurred at the restigation, in m	time, date and y opinion, deat	d place, and the occurred a	due to the cause( t the time, date ar	s) and manner as s nd place, and due to	tated. o the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier					ense number	7	29d. D	ate signed (Month,	Day, Year)
1	0.0						D	1991	(	2	12404	
)	40		30. Name and address of person who Dr. James C. Boyd, Wi	,				Maryland	d 20619	1	i	
	Sta		31. Date filed (Month, Day, Year)		trar's Signa	ture	not n					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 26 12:25 AM WILLIAM ARTHUR SMITH APRIL 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHARLOTTE HALL VETERANS HOME ST. MARY'S CHARLOTTE HALL | CHARLUILE | DALL |
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) |
| OCT. 29, 1920 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 €M 2 □ F ARKAŃSAS 83 Director 459-09-3080 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show ral", or Itams 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director MD LAUREL ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3358 SUDLERSVILLE SOUTH 20724 U. S. A. death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? WXYes 2CINO W.W.II IYYes. Give Year or Dates: & KOREA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced WHITE natural the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FEED INDUSTRY 12 MAINTENANCE ELECTRICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nd Mental ! of Health and Mental: If item 27 is marked (UNAVAILABLE) (UNAVAILABLE) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACKIE N. FLEEMAN/STEP-SON 3358 SUDLERSVILLE SOUTH LAUREL, MARYLAND 20724 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State APRIDate 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. CHELTENHAM, MARYLAND MD VETERANS CEMETERY 29, 2004 \* 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBRINSFIELD-ECHOLS FUNL.HME., P.A. Losen 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 0 in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown 9 Unknown signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ EMENTIA, CEPTEBROVASCULAR ACCIDENT 1 🗌 Yes 2 🗌 No 3 ☐ Probably 4 ☑ Unknown Completed CHRONIC OBSTRUCTIVE PYLMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed3 HYPERTENSION 2E No PULMONARY NODULE, 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ို 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 🗌 Homicide 24 hours a filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely within 2 To the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) APR 28 State Registrar

		State of Maryland / Dep	partment of Health and Mo ertificate of Death		ne 2004	14708
Physic		1. Decedent's Name (First, Middle, Last)  Frank J. Sheehan		2. Date of Death  Month April 19	Day 2004 Year	3. Time of Death 5:50 a M
/Med Exam		4a. Facility Name (If not institution, give street and number) William Hill Manor	4b. City, Town, or Location of Death  Easton		4c. County of Death Talbot	= 2
Funera Directo		5. Social Security Number 487-01-9342 6. Sex 1 M 2 F 85 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Feb. 23,	9. Birthp MPS MPS 1	lace (State or Foreign
Maryland f show	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or  Maryland Talbot Eas:			1	0d. Inside City Limits
with the 7	Funeral Director	10e. Street and Number 201 Federal Street	10f. Zip Code 21601	10g.	Citizen of What Cour	try?
I E, INIAL YIAIII A FILE 13-0050  1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. 1 the site marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examina must be notified at	þ	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	B. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify:	etc.
ithin 72 horan	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	eedent's Usual Occupation re kind of work done during most of workin . DO NOT use retired)	g 16b	. Kind of Business/Ind	dustry
yland 21 buid be filed w Mental Hygier arkad other th	Be	17. Father's Name (First, Middle, Last)	Salesman 18. Mother's Name			pplies
and Men and Men is marka	2	1,121	iling Address (Street and Number or Rural	Cunningha Route Number, Ci		Code)
E, M 1 and 2 Health em 27 i			8 Williwood Rd., Fa	7	le,NC 283 . Location - City or To	
0 0		I Li Bunai 2 Micremation 3 Linemoval from State 1	position (Name of Prematory or other place)  CremationCenter4/22			
permit. Pages Department of Important: If i		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mid Shore Crematior 2272 Hudson Rd., Ca	Center,	P.O. Box MD 21613	1464
Pnysicia		23a. Rant-Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	inter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
w requires that the death certificate be executed we been signed by the attending physician and should be detached for use as the burial-transit on pro-	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Desem W. M. Brain	Stem S	Stroke	10 yrs
The Coll (15), F.O. BOX 00  The law requires that the death certifical ate has been signed by the attending phyape 2 should be delached for use as the	Physician/Med		B∐Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
wrequires that been signed b	ed by Pt	Part II. Other significant conditions contributing to death but not resulting in the Ewal Distart on	underlying cause given in Part I.	23e. Did tobaco	co use contribute to th 2⊠No 3 Prob	e cause of death?
The law re ate has bee page 2 sho	Completed by	Diabetes Melletas	esare	24a. Was an autopsy performed 1 Yes 2	prior to cor death?	osy findings available inpletion of cause of
SION OI VIIAI MEN tending Physician: The lav Beath. tor: After this certificate has the funeral director, page 2	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	of 28c. Injury at 2		e 6 □Other (Specify	·)
Z Z Z Z Z	Certification;	2 Accident 3 Suicide 4 Homicide  investigation 6 Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)		8f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
To the within To the comp	×	29b. Signature and title of certifier  William Hward Mi	29c. License number 788715	29d.	Date signed (Month, )	Oay, Year) •
		30. Name and address of person who completed cause of death (ten 23a) (Typ William H. Wood, Jr., M.D. 28474		Easton,	MD 21601	
S Regis	tate strar	31. Date filed (Month, Day, APPR 2 1 2004 Signature	* book			

			1 - For State Registrar	Olulo of			tificate			Mental Hy	Reg. No.	711111	14709	-
	n de		1. Decedent's Name (First, Middle	, Last)						2. Date of D	eath Day	/ Year	3. Time of Death	
	Physici /Medio		Lillia	an U. Smoo	t					Apri1	12	2004	6:15 P M	
A. C.	Examin	ier	4a. Facility Name (If not institution				,		Location of Deat		4c.	County of Death		
			Fairland Nursi				If Under 1		er Sprin			Montgo		
	Funeral		5. Social Security Number 579-12-4117	6. Sex 7	. Age (In yrs. I		Months		Hours Min.	(Month, D	ay, Year)		place (State or Foreign intry)	
	Director	ļ	Usuel Residence of Decedent			95 Yrs.				May 22	2, 19	08   Was	sh., DC	
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Mar B-f st	ţċ	Maryland Mon	tgomery				Silv	er Sprin	10			1 ☐XYes 2 ☐ No	
	or 28.	Director	10e. Street and Number				10f. Zip (		ar opin	•	10g. Citi	izen of What Cou	intry?	
	23a (23a)	ai	2101 Fair	land Road					20904			Unit	ed States	
	r dea	Funeral	11. Marital Status	12. Was Deced	es?	5. 13. V	Vas Decede Yes, specif	ent of His fy Cuban	panic Origin? (S , Mexican, Puerl	pecify Yes or No o Rican, etc.)	0-	14. Race - Ameri Black, White		
	or fr	٦.	1 Never Married 2 Marri	If Vac Give	X No		□Yes 2		Specify:				Black	
	hour tural	Be Completed by	3 → Vidowed 4 □ Divorced  15. Decedent		es:	16a. Deced	ant's Hevel	0000000	No.		105 16	-		
	in 72	Set	(Specify onty highes	st grade completed)		(Give	kind of work	done du retired)	iring most of wo	rking	100. KI	nd of Business/Ir	idustry	
	than in the	E	Elementary/Secondary (0-12) 12th	College (1-	for 5+)			nemal				Priva	1 + 0	
	Hyg other	O	17. Father's Name (First, Middle,	Last)			1101		18. Mother's Nar	ne (First, Middle	, Maiden		LLE	
	Menta Menta rked tic ev	To B	William J	. Davis						Regina	Ha1	1		
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or trems 23a or 28a-f show ammatic event, the Madical Eart-liter rust be nutilised at aumatic event,	_	19a. Informant's Name/Relationsh			19b. Mailin	g Address (	Street a	nd Number or Ru	ral Route Numb	er, City o	r Town, State, Zi	o Code)	
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Merial Hygiene titem 27 is marked other than "natural", or thems 23a or 28a-f show item 27 is marked other than "natural", or there is not be notified at other traumatic event. The Madical Examitment and be notified at		Renee Macklin	- Grandda	ughter	16	6608 N	Norbe	eck Farm	Dr., 0	1ney	, MD 20	832	
	of He of He fiten		20a. Method of Disposition 1   ↑ Burial 2   ☐ Cremation	3 Demoval from S		ace of Dispos metery, cren	sition (Name natory or oth	e of ner place	)	Date	20c. Lo	cation - City or T	own, State	
	Pag ment ant: I		4 □Donation 5 □Other (S)	Decify)	Line	coln Me	emoria	al C	em. 4/16	/2004		Suitland	. MD	
	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Sign sture of Funeral Service I	Licensee		22	Name and	Address	of Facility S	tewart		ral Home		
	8258		John 1.	Merrell	TIL				ing Rd.,			DC 20	019	
			23a. Part Enter the disease, or shock or heart failure. List	complications that ce only one cause on ea	used the deeth ch line.	. Do not ente	er the mode	of dying	, such as cardiad	or respiratory a	rrest,		Approximate Interval Between	
Ī	Pnysician	1	Immediate Cause (Final disease or condition	My	ocardia	ıl Infa	arctic	n					Onset and Death	
1	/Medical Examiner		resulting in death)	Due to (o	r as a consequ	ence of):								
	Lammer	_	Sequentially list conditions,	b. Due to /e		f\.	_						<del></del>	-
•	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause to isease or injury	Due to (o	as a consequ	ence or):								
	ate be executed nysician and he burial-transit	xan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	as a consequ	ence of):								-
	i be ex sician a burial	caiE												
	ficate physis the			a										
	nding nding use a	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							2	23d. Date of deliv	ery	
4000	oeau e atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregna	h 2 Fetel nt at time of de		Ectopic pred Other (spec					Month	Day Year	
t the	ed by the attending ph detached for use as the	Physician/Med	9 Unknown	9□ Unknov	'n					Υ				_
	w requires that been signed to should be deta	by P	Part II. Other significent condition	ns contributing to dea	th but not resu	lting in the un	derlying cau	use giver	n in Part I.	23e. Did	obacco u	se contribute to t	he cause of death?	
	aquire en siç ould b	edt	Hyperter	nsion		_				10	Yes 2	□No 3□Prot	oably 4 ∑Vnknown	
	s ber	piet								24a. Was		24b. Were auto	ppsy findings available impletion of cause of	
										perfe	ormed? 2 TrNo	death?		
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	nysician: The land is certificate had director, page 2	Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 🔲 Inj	oatient 2 🗆 E	R/Outpatient	3□ DOA	Other				Other (Specif	(y)	
	ng Physician: The la fter this certificate ha neral director, page 2	To Be	examiner?  1 Yes 2 No  27. Manner of Death	28a. Date of		28b. Time of		Other	Nursing H		dence 6		(y)	
ALL DELLE PROPERTY OF THE PARTY	ending Proystctan: The iseath. or; After this certificate has the funeral director, page 2	To Be	examiner?  1 Yes 2 X No  27 Manner of Death  1 X Natural 5 Pendin. 2 Accident investig	28a. Date of (Month)	Injury			Other c. Injury : Work?	Nursing H	ome 5 Resi	dence 6		(y)	
	or Attending Physician: The later death. itector: After this certificate ha itector, page on the funeral director, page.	To Be	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month) guation not be 28e. Place of	Injury	28b. Time of Injury	28 M	C. Injury : Work?	Nursing H	ome 5 Resi 28d. Describe	dence 6 how injury	y occurred d Number or Rura	y) al Route Number,	
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Moonite! or	within 24 hours aller death.  To the Funeral Director. After this certificate ha completely filled in by the funeral director, page?	Certification; To Be	examiner?  1 Yes 2 No  27 Manner of Death  1 Natural 5 Pendin investig  3 Suicide 6 Could r determi  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and 13 ress of person of	28a. Date of (Month) pation not be 28e. Place of building g Physician: To the bear and manner who completed cause	Injury Day Year)  Injury - At hore, etc. (Specify, est of my know is of examinating stated.	28b. Time of Injury  ne, farm, stre  /ledge, death on and/or inv  23a) (Type, F	M  et, factory,  occurred at estigation, ii  29c.	Other c. Injury a Work? 1 TY office t the time in my opin License	Nursing Hat  s 2 \( \text{No} \)  n, date and place nion, death occu number  4488	ome 5 Resi 28d. Describe 28f. Location ( City or To: , and due to the rred at the time,	dence 6 how injury Street and wn, State) cause(s) date and	occurred  d Number or Rura  and manner as s place, and due to e signed (Month,	tated. to the cause(s)  Day, Year)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director, After this certificate completely filled in by the funeral director, pag	Medical Certification; To Be	examiner?  1	28a. Date of (Month) aption be beined 28e. Place of building g Physician: To the bexaminer: On the bas and manner who completed cause 60, M.D.	Injury Day Year)  Injury - At hor, etc. (Specify, est of my know is of examinating stated.	28b. Time of Injury  me, farm, stre  yledge, death on and/or inv  23a) (Type, F	M  et, factory,  occurred at estigation, ii  29c.	Other c. Injury a Work? 1 TY office t the time in my opin License	Nursing Hat at as 2 No a, date and place nion, death occu	ome 5 Resi 28d. Describe 28f. Location ( City or To	dence 6 how injury Street and wn, State) cause(s) date and	occurred  d Number or Rura  and manner as s place, and due to e signed (Month,	tated. to the cause(s)  Day, Year)	
	To the Hospital or Attending Physician: The limiting 4 hours after death.  To the Funeral Director; After this certificate ha completely filled in by the funeral director, page?	Medical Certification; To Be	examiner?  1 Yes 2 No  27 Manner of Death  1 Natural 5 Pendin investig  3 Suicide 6 Could r determi  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and 13 ress of person of	28a. Date of (Month) pation not be 28e. Place of building g Physician: To the bexaminer: On the bas and manner who completed cause 50, M.D. 32. Reg.	Injury Day Year)  Injury - At hore, etc. (Specify, est of my know is of examinating stated.	28b. Time of Injury  me, farm, stre  yledge, death on and/or inv  23a) (Type, F	M  et, factory,  occurred at estigation, ii  29c.	Other c. Injury a Work? 1 TY office t the time in my opin License	Nursing Hat  s 2 \( \text{No} \)  n, date and place nion, death occu number  4488	ome 5 Resi 28d. Describe 28f. Location ( City or To: , and due to the rred at the time,	dence 6 how injury Street and wn, State) cause(s) date and	occurred  d Number or Rura  and manner as s place, and due to e signed (Month,	tated. to the cause(s)  Day, Year)	

		•	State of Marylan	d / Department of Health and M Certificate of Death	
₹	4		Registrar	Ooramouto of Boats	2. Date of Death 3. Time of Death
	Physicia /Medic	-	1. Decedent's Name (First, Middle, Last)  Keyonna R. Slaughter		Month Day Year 1410 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Since George's Hospit		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)
	Director		220-15-0720 1□M 2XF 28		May 13, 1975 Wash., DC
	D		Usual Residence of Decedent	-	10d. Inside City Limits
	how		10a. State 10b. County 10c. Cit	y, Town or Location	1 □XYes 2 □ No
	e-f s	cto	Maryland Prince George's	Capitol Heights	
	h the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	h wit		1314 Karen Blvd.	20743	United States
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	<ul> <li>S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ul>	ecify Yes or No-  14. Race - American Indian,  Rican etc.)
ယ	after or fte	Fu	1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 <b>②</b> No Specify:	2111110011
03	ours a	þ	3 Widowed 4 Divorced Year or Dates:	The sea 2X No Specify.	Specify: American
9	72 hours after death with the Maryland natural', or thems 23a or 28e-1 show dical Exam, nor must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b. Kind of Business/Industry
21	within 7 ene. than "r	ple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
21215-0036	filed with Hygiene. ither thai	Completed	1	Administrative Assist	tant Private
D	il Hygie other	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)
a	lid be lental rked c	To B	William H. Slaughter		Linda Dean
Maryland	2 should be filed w and Mental Hygie is marked other t raumatic svsnt, II.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)
	5 = 2 :		Linda Lesene - Mother	1314 Karen Blvd., Cap	pitol Heights, MD 20743
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 sny injury or other tr. once.	1	Loan mountain	Place of Disposition (Name of semetery, crematory or other place)	Date 20c. Location - City or Town, State
9	Pages nent of int: If it		1 LtyBurial 2 L Cremation 3 L Hemoval from State	mony Memorial Park 4/17	/2004 Landover, MD
==	nit. Partmen ourtent: injury	1 3	21. Signafure of Poneral Service Licensee		tewart Funeral Home
Ba	permit. Departm Importe sny inju		Loun T. Sterons II		., N.E. Wash., DC 20019
			23a Part I Enter the disease or complications that caused the deat		or respiratory arrest Approximate
43.1			shock or heart failure. List only one cause on each line.		Onset and Death
	Physician /Medical			thicle Accident with	Closed Head to un
	Examiner		Due to (or as a conseq	uence or):	
		-	Sequentially list conditions.  thany leading to immediate  Due to (or as a consequence)	uence off.	
	ed set	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	be executed icien and burial-transit	хаг	that initiated events c. resulting in death) Last Due to (or as a conseq	uence of):	
760,	e be ex sicien e burial	calE			
687	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the		d		
×	ding se as	We.	IF FEMALE: 23c. If yes, outcome of pregna	ancy	23d. Date of delivery
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Feta		Month Day Year
P.0.	the de	ysic	1 Yes 2 No 9 Unknown		
	that the	by Physician/Medi	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Division of Vital Records,	sign d be	ğ			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown
0	w requir been si should	tec			
ec	alaw hast e.2 s	Completed			24a. Was an autopsy findings available prior to completion of cause of death?
=	The pag	ပ္ပ			1 Yes 2 No 1 Yes 2 No
/ita	Attending Physician: If death.  •ctor: After this certification in the funeral director.	Be	25. Was case referred to medical examiner?		h (Check only one)
=	hysi his c	2	Yes 2 No Hospital: Inpatient 2		ome 5 Residence 6 Other (Specify)
_	ng P fter t	5	27. Manner of Death  1 Natural  5 Pending  28a. Date of Injury (Month, Day Year)	Injury Work?	28d. Describe how injury occurred Dy ver of
0	andi sath. or: A he fu	at	2 Accident investigation April 8 2004	2350 M 1 Yes 22No	collisient
<u>≅</u>	er de rect	ŧ	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specific Could not be determined 28e. Place of Injury - At h building, etc. (Specific Could not be determined 28e. Place of Injury - At h	ome, farm, street, factory, office	28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 9 00 01 1 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	tal or rs afte el Dir ed in	Cer		STreel	thee Road Southand, Mangland
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification:		owledge, death occurred at the time, date and place, ation and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	- s + ō		I Salvard phate of	10005 82	1 April 13 2006
0	[1]		30. Name and address of person who completed cause of death (Iter	m 23a) (Type, Print)	7
	(2)		SALVA dor Sylvator, 3 and 140	saital Drive, Chow	ely hang land
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ature	1
1	Regist		APR 1 6 2004	Grand	

		For State Registrer  1. Decedent's Name (First, Middle, L	State of		Ce	rtificate	of L	Death		2, Date of De	Reg. No.	200	3, Time o	of Death
Physicia		Enid Simons	431/								13, Day	2004 <sup>Ye</sup>		
/Medic Examin		4a. Facility Name (If not institution, g.	ve street and num	ber)		4b. City, 7	Town, or	Location of		-		County of D		<u> </u>
LXamiii	C1	Southern Maryla				C	lint	ton			P	rince	George	
Funeral Director			Sex 7 1 □ M 2 💢 F	7. Age (In yrs. 90	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Bi (Month, Da March	th ay, Year) 19,	9. I 1914	Birthplace (State Country) New Yor	or Foreign k
<b>8</b>	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside C	City Limits
short in	ō	MD Prince	?eome		emple								į .	s 2 □ No
28a-	rect	10e. Street and Number	GCGLGC			10f. Zip					10g. Citiz	zen of What	Country?	
3a or	Ö	4806 Wood Road				2	0748	В			1	USA		
rel', or items 23a or 28a-f show Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13.	Was Deced	ent of H	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	p- 1	14. Race - A Black, W	merican Indian,	
or th	by Fu	1 ☐ Never Married 2 ☐ Married	1 □Yes 2 If Yes, Give	2 [ <b>X</b> No		1 ☐ Yes 2		Specify:			-	Specify:	Black	
"naturel", olical Exa	q pe	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's	Year or Da	105:	16a, Dece	dent's Usua	I Occupi	ation			16b. Kir	nd of Busine		
Andic Andic	Completed	(Specify only highest g	rade completed)	405 5.)	(Give	kind of wor DO NOT us	k done d	during mos	t of workir	ng			-	
£ 3	E	Elementary/Secondary (0-12)	College (1-	401 5+)	Chi	ld Car	e				Do	mesti	3	
vent.	Be C	17. Father's Name (First, Middle, Las	it)							(First, Middle		Sumame)		
arke	To I	James Bruton								e Willi				
Important: If item 27 is marked other then "natur any injury or other traumatic event, the Middle 2006.		19a. Informant's Name/Relationship			1					I Route Numb			e, <i>Zip Cod</i> e)	
am 27 ther t		Dollene Harris/ 20a. Method of Disposition	Daughter	20b. F	48Ut	V		, Tem		Hills,			or Town, State	
or of		1 Burial 2 ☐ Cremation 3			emetery, cre nelawi	matory or of	her plac	ээ) У ¦	4/19,				ale, NY	
njury F.	-	*4 □ Donation 5 □ Other (Spec 21. Signature ■ Funeral Service Uic		1		2. Name and		1	, ,		and E	inera	l Servic	'es
any ii		Morly	At all	Carl						Camp Sp				CO
		23a Part . Enter the disease, or co			h. Do not en	ter the mode	of dyin	g, such as					Approxima Interval Be	ite tween
sician		shock, or heart failure. List on Immediate Cause (Final	y one cause on ea	D (	Pinn	to ALL C							Onset and	Death
ledical		disease or condition resulting in death)	a. Due to (d	or as a consequence	uence of):	o re a							CAICAS	~~
aminer		Sequentially list conditions.	b	ol me	my F	=, bs	05-	2					un Kno	<u>ب س ر</u>
it.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to to	or as a conseq	uence #):									
and I-tran	хаш	that initiated events resulting in death) Last	c	or as a conseq	ruence of);									
physician and the burial-transit	ical E													
LL (0			0											
attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo			∃Estania ne					2	3d. Date of		
been signed by the attendin should be detached for use	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregna	nth 2 ☐ Feta ant at time of d		⊒Ectopic pre □ Other <i>(sp</i> e						Month	Day	Year
tache	hys	9 🗆 Unknown	9 Unkno	wn							1/2	100000		
pe de	by	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	inderlying ca	use giv	en in Part I				_	to the cause of	_
onld bluo										10	Yes 2			Laknown
28	Completed									24a. Was	psv	24b. Were prior death	autopsy findings to completion of	available cause of
pagi,	S									1 ☐ Yes	ormed?	1 0	es 2□No	
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	/			Δ Oth	er.		(Check only				
this ral dir	<u>5</u>	1 Yes 2 DW	1 114	and the second second	ER/Outpatie		A Bc. Injun	7 140		ne 5 Res 28d. Describe			pecify)	
After	tion	1 D Matural 5 ☐ Pending 2 ☐ Accident investigat		f Injury n, Day Year)	Injury	М	Wor	k? Yes 2.⊟	No					
octor by the	ifica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place	of Injury - At h	ome, farm, st	reet, factory	, office		1		(Street and		Rural Route Nur	nber,
d in t	Certification:	4  Homicide	bullain	g, etc. (Specil	ry)					Ony or ro	wii, Siaie)	1		
To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (	29a. Certifier 1 Certifying (Check only one)	Physicien: To the eminer: On the ba and mann	sis of examina	owledge, dear ation and/or in	h occurred a	at the tin	ne, date an pinion, dea	d place, a	and due to the	cause(s) date and	and manner place, and	as stated. due to the cause(	s)
To the	Med	29b. Signature and title of certifier	and mann	or stated.		29c	. Licens	e number			29d. Date	e signed (Me	onth, Day, Year)	
⊢ ŏ		11 Sty	olllen			-	04	54			PO.	1.1	3104	
1		30. Name and address of person wh	o completed cause	e of death (Iter	n 23a) (Type		- [	3 1		/	1/20	7)	3/01	
,			Ave s	int 3	-41		ven	SPR	ing	MD 2	070	2		
	ate	31. Date filed (Month, Day, Year)	37 Re	gistrar's Signa	ature				0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \int \) For State Registrar Amend #31, Per VR PCC 4/16/04cr Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 12:15 AM April 3, 2004 STURGHILL HARVEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Capital Heights Prince George's 4814 Gunther Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 14,1935 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1₽M 2□F Months Hours 68 Tennessee 410-64-1866 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 Yes 2 □ No Capital Heights Directo Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20743 4814 Gunther Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No 9/2/55 If Yes, Give Year or Dates: to 9/1/66 1 Never Married 2 X Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Xerox Corp. Machine Operator 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic even 90x8. Be Lydia Edmond Lieutenant Sturghill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4814 Gunther St. Capital Heights, MD 20743 Iorraine Sturghill/Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Cecametery: crematory or other place) 04/10/2004 Suitland, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service See 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746 P. I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Death trimeciale Cause (Final dinease or condition resulting in death) **Physician** Metastic Colon Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, o come of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 3 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Yes 2 XNo Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52767 04-1051 2004

Registrar

filed within 72 hours after death with the Maryland

al Hygiene.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

or Attending Physiclan:

Hospital

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attending physicien and

the

certificate has

After this

DHMH 17 Rev 1/2001

State

Mayer

32. Registrar's Signature

50 W. Edmonton Dr. Suite 303 Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

Harminder S. Sethi, M.D.

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0 0 4 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** LORELIA SMTTH 13, 2004 April 1:50 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fox Chase Rehab & Nursing Center Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 1, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖸 F Virginia 227-18-5206 90 1913 Director Usuel Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1√2 Yes 2 No Director D.C. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19 U Street, N.W. 20001 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itel any injury or other freumatic event, the Medical Examinations. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black <u>۾</u> 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerk GOV. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Ferris Mary Green 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Shannon, Executor 1420 N St.N.W. Wash.D.C. 20005 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lincoln Mem. Cemetery Apr. 19,04 Suitland, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hunt Funeral Home Trances 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Renal Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? Congestive HEart Failure cate has t page 2 s autopsy performed? Hypertension 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☑ No or Attending Physicien: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ٩ After this funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No M death. Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D28656 April 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D. 8609 2nd Ave. Suite 404B Silver Spring, MD. 20910 31. Date filed (Month, Day, Year) APR 2 0 2004 State Registrar

			1 = For State Ragistrer	State of Maryland /	Department of F	lealth and N Death		ene 2001	+ 14711	
			Decedent's Name (First, Middle, Last	)			2. Date of Death Month		3. Time of Death	
į,	Physicia /Medic		Warren C. Smith	Jr.			April	15 2004	6:30 A M	
R.	Examin		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, o	r Location of Death		4c. County of Deati	1	
			1931 BARRINGTON (		MITCHEL	LVILLE If Under 24 Hrs.	8. Date of Birth (Month, Day, 12 25	PRINCE G	EORGE S	
	Funeral Director		5. Social Security Number 6. Se 119-34-5062	M 2 TF 61	Yrs. Months Days	Hours Min.	(Month, Day, )	1942 New	York	
			Usual Residence of Decedent							
	nylan how		10a. State 10b. County		vn or Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	8a-f	Director	MD Prince C	eorge's Mitch	nellville		140	g. Citizen of What Co	Λ	
	with the		10e. Street and Number 1931 Barrington	Court	10f. Zip Code 20721			U.S.A.	untry	
	within 72 hours after death with the Maryland ene. Then "netural", or Items 23a or 28a-f ehow he Medical Exatta nor most be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Sp		14. Race - Ame		
0	riter d	F	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto Specify:	o Hican, etc.)	Black, White		
e S	rai', c	d by	3 ☐ Widowed 4 🙀 Divorced	Year or Dates:	TENTES ZEALNO	эрөспу.			lack	
Maryland 21215-0036	72 h	Completed	15. Decedent's Edi (Specify only highest grad		<ol> <li>Decedent's Usual Occup (Give kind of work done life. DO NOT use retired</li> </ol>	nation during most of work	king	6b. Kind of Business/	Industry	
121	within ane. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Police	۵)		Gov't		
0 7	Hygid Hygid Sther		17. Father's Name (First, Middle, Last)	<del></del>	TOTICC	18. Mother's Nam	ne (First, Middle, M		-	
lan	id be lental ked c	To Be	Warren C. Smith	Sr.		Pinkie	Irene Huc	kless		
ary	should Name		19a. Informant's Name/Relationship (7	•	b. Mailing Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	(ip Code)	
Σ,	and 2 ealth n 27 i		Linda Smith/Daugh		.931 Barring	ton Court			*	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Endit are must be notified at ance.		20a. Method of Disposition  1  Burial 2 Cremation 3	cemete	of Disposition (Name of ery, crematory or other pla	l l		0c. Location - City or		
Ē	: Pag tment tant: ijury		*4 □ Donation 5 □ Other (Specify		dale Cremat		POTENTIAL DESIGNATION OF THE PARTY OF THE PA	Riverdale,		
Bai	Depar Impor Impor Impor Impor Impor		21. Signature of Funeral Service Licen:		22. Name and Addre	over Road	B. Jenki Landovei	ns Funera r, Marylan	L Home d 20785	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do					Approximate	
100	Diam'r 1-1		Immediate Cause (Final						Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Metastatic v  Due to (or as a consequence		norna				
E	Examiner		Control No. Control Mariana	b						
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a sonsequence	oth:					
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence	a offi					
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687	physicate sthe			d						
× e	The law requires that the death certificate the has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of del	ivery	
Вох	d for u	Iclar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	th 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y 		Month	Day Year	
O.	that the de ed by the detached	hys	9 Unknown	9□ Unknown			===			
o.	es tha igned be del	by P	Part II. Other significant conditions of		in the underlying cause gr	ven in Part I.		23e. Did tobacco use contribute to the cause		
ord	w require been signal	ted	Hypertensio	<u>^</u>			1 🗆 Yes	s 2.10 3 □ Pr	obably 4 🖾 Unknown	
Records,	e law r has be	ompleted	Diabetes				24a. Was an autopsy	prior to	topsy findings available completion of cause of	
=		Son					perform 1 Yes 2		2√∑ No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Ot	hon	ath (Check only one			
of	Phys this ral dii	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 □ Inpatient 2 □ ER/C	. Time of 28c. Inju	4 🗆 INUISING I	28d. Describe how	nce 6 Other (Spec winjury occurred	city)	
on	Attending r death.	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		rk? ]Yes 2□No	, , , , , , , , , , , , , , , , , , , ,			
Division	l or Attendia after death. Director: A	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,	
ā	s after al Dire	Certification:	4   Normolde	building, etc. (Specify)			0.,			
	To the Hospital or within 24 hours after To the Funeral Director completely filled in E		29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my knowled inar: On the basis of examination a	ge, death occurred at the transformation in my	me, date and place opinion, death occu	e, and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)	
	the H hin 24 the F nplete	Medical	one)	and manner stated.		se number		d. Date signed (Mont		
	To To Poor	-	29b. Signature and title of ceptifier	dulua		739/	23	04-16-0		
17	1-5		30. Name and address of person who	deplus						
H	0		Rochelle S. He	M.D 12	(Type, Print) 172 Centra	al Aver	# 100 M	itchellville	C MD 2072	
2	St	ate	31. Date filed (Month, Day, Year)  APR 2. 0. 2004	32. Registrar's Signature	1. 4.					
			- ADD 7 A 700A							

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ORIGINAL

		•	State of Maryland / Depar	tment of Health and ificate of Death	l Mental Hygie	2009	14715
	· · ·		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		MAXINE A. SHEESLEY		APRIL	14, 2004	8:00₽ <sup>M</sup>
	Examin		,	4b. City, Town, or Location of Dea	ath	4c. County of Death	
			SOUTHERN MARYLAND HOSPITAL CENTER  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	CLINTON If Under 1 Year   If Under 24 Hi	rs. 8. Date of Birth	PRINCE (	GEORGES place (State or Foreign
	Funeral Director			Months Days Hours Mi		1917 Cou	OHIO
			Usual Residence of Decedent				
	larylan show	ايا	10a. State 10b. County 10c. City, Town or Local				10d. Inside City Limits  X1X□Yes 2 □ No
	ith the Maryla or 28a-f sho	Director	MARYLAND PRINCE GEORGES TEMPLE HIL	LS 10f. Zip Code	100	. Citizen of What Cou	
	with t	D	10e. Street and Number	20748		ITED STATE	•
	ns 23	Funeral	5704 OLD TEMPLE HILL ROAD  11. Marital Status 12. Was Decedent Ever in U.S. 13. We	as Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pue		14. Race - Ameri	icen Indian,
to	after o	듄	1 □ Never Married 2 □ Married   XiX Yes 2 □ No 1944-	Yes, specify Cuban, Mexican, Pue ⊒Yes XXX No <i>Specify:</i>	erto Rican, etc.)	Black, White	
<b>DX</b> 0036	v) - 19	d by	3XXWidowed 4 □ Divorced If Yes, Give Year or Dates: 1946			Specify: WH]	
<u>5</u> 5	"natural"	Completed	(Specify only highest arade completed) (Give kii	nt's Usual Occupation ind of work done during most of w O NOT use retired)	vorking 16t	b. Kind of Business/Ir	ıdustry
2 2	within ana. than "	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	IVE ASSISTANT		STATE FARM	INSURANCE
<b>©</b> 2	be filed tal Hygid d other evant, I	Be C	17. Father's Name (First, Middle, Last)		ame (First, Middle, Mai		- INDOIGH OF
ļa .		To B	GEORGE ACKER	NINA C	GARN		
ary a	and and Is m	1 8	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or I	Rural Route Number, C	ity or Town, State, Zi	code)
ρs	s 1 and 2 if Health itam 27   other tru			CAST BANCROFT LA		CROFTON,	
2 Por	of H of H ita		#MANUFIAI 2 Cremation 3 Memoval from State	atory or other place)		c. Location - City or T	
I		1	. 4 □ Donation 5 □ Other (Specify) CEDAR HILL  21. Signature of Funeral Service/Nicensee ↑ ↑ ↑ 22.4		The state of the s	SUITLAND,	
4. Balt	permit. Departr Import any inj		MA MA	Name and Address of Facility RSHALL'S FUNERA 308 SUITLAND ROA		MARYLAND,1 ND, MD 207	
			23a. Part 1. Etter the disease, or complications that caused the death. Do not enter shock, of heart failure. List only one cause on each line.		iac or respiratory arrest,		Approximate Interval Between
	Enysician	0 16	Immediate Cause (Final disease or condition  ACUTE CENSMO	NASCULAR &	ACCI DEDU	7	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	Fig (Al) iou	MCA. V.A.	Nicele	1400
	Examine:		Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	M CARUSIUI	MOULEN	DUSAST	4547
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury				
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/8	entifica ling ph e as th	hysician/Medical	IF FEMALE:	· · · · · · · · · · · · · · · · · · ·			
	ath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
.50	at the de by the a tached	ysic	1 ☐ Yes XXNo 9 ☐ Unknown 9 ☐ Unknown	Jillel (specify)			
3 -	requires that the death een signad by the atter nould be detached for u	by Ph	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
<b>Z</b> §	w require been sig should b		CANCER OF YETE COLONIC	WIH WER	1□ Yes	2 No 3 Pro	bably 4 Lunknown
000	s b	ompieted	•		24a. Was an autopsy	24b. Were auto prior to co	opsy findings available ompletion of cause of
>=	Th ate pag	Соп			perfórméd 1 □ Yes X2X	d? death? INo 1□Yes	2□ No
N Signal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other	eath (Check only one)		
50 0	Phys this rat dia	To	1 Yes 2 KNO 1 Infinpatient 2 ER/Outpatient		Home 5 Residence		<i>(y)</i>
9 5	ding I th: : After a funer	tion	27. Manner of Death  1. ■Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day Year)  Injury 28b. Time of Injury (Month, Day Year)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			
Visi	or Attan after deat Director: in by tha	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	t and Number or Run State)	al Route Number,
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	FL TO	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invegand manner stated.  2 Medicel Exeminer: On the basis of examination and/or invegand manner stated.				
سدر	To the Hos within 24 hr To the Fur completely	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			· ////	1) 1854	A	RIL 15	2004
16	) 1 Va		36 Name and address of cerson who completed cause of death (Item 23a) (Type, Proceedings of Complete C	INE COUTER	WALKONE	ud.	20602
(6)	Sta <b>Regi</b> sti		31. Date filed (Month, Day, Year)  APR 2 0 2004	U			

			For	Pleas			and / Depa	artment of H	lealth	and M			Legible.	
			1 - State Registrar Certificate C							<b>ו</b>	2. Date of D			3. Time of Death
	Physicia /Medic		Edward	W							7:02 A M			
	Examin		4a. Facility Name (h		-	number)		4b. City, Town, o Lanhan		of Death		1	c. County of De	<sup>ath</sup> George's
I	Funeral Director		5. Social Security N 579-12-0	lumber	6. Sex 1 🔀 M 2 🗆 F		yrs. last birthday) 30 Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of B (Month, D	irth Day, Year 18 19	9. B 023 Was	inthplace (State or Foreign Country) Shington, D.(
death with the Maryland	Maryland f show	lor	Usual Residence of 10a. State MD	10b. County	e George		. City, Town or Lo	cation						10d. Inside City Limits
	with the s or 28a be notifi	Director	10e. Street and Nur	mber				10f. Zip Code				10g. C	itizen of What 0	Country?
	be lited within 72 hours after death with the Marylan lat Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Madical Exament must be notified at	by Funeral	5724 Hi  11. Marital Status  1 Never Marri 3 Widowed	ied 2⊠ Marri	12. Was De	Forces? s 2 □ No Bive WOR	t Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. F E No WORLD WAR 1 □ Yes 2 ☑ No Specify: Spe						14. Race - An Black, Wh Specify: B	nite, etc.
9500-61212	within 72 hou ene. than "natura he Medical E	Completed	(Spec		's Education t grade completed	-	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	during mo	st of worki	ing		Kind of Busines	•
	e filed with Hygiene other the vent, the	Be Com	12th. 17. Father's Name				Sa	lesman			e (First, Middl	e, Maide	artment n Sumame)	Store
<b>=</b> .	O /	ToB	Edward :		nip (Type, Print)		19b. Maili	ng Address (Street			Shield al Route Num		or Town, State,	Zip Code)
	1 and 2 Health a em 27 I; ther tra		Mary Brace 20a. Method of Dis	cey position	Daughte	aughter 5724  20b. Place of Dispo cametery, cref			matory or other place)			20c. L	06 Location - City on twood,	
	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Marshall's Funeral Howard Part Language 4217 9th. St. N.W. Washington, D.C. 2									Home		
	Physician /Medical Examiner	23-103	23a. Part 1. Entershork or heal Immediate Cause disease or condition resulting in death)	(Final on	a. Re	spirat	death. Do not ent	er the mode of dyir	ng, such a		Approximate Interval Between Onset and Death 3 hrs.			
	uted Insit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	onditions, nmediate erlying injury	Ca		yopathy							5 yrs.
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. Box	the death certificate be y the attending physici iched for use as the bu	by Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 20 9 ☐ Unknown	□Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day *					
	w requires that the di been signed by the should be detached												pacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 □ Unknown	
	The lar	Completed									24a. Wa aut per 1 \( \text{Yes}	opsy formed?	prior to death?	autopsy findings available completion of cause of es 2 \square No
	eician: certific irector,	Be	25. Was case reference examiner?		26. Place of Death (Check only one)   Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA   Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (s							6 □Other (Sc	necifu)	
Division of	Attending Physician: r death. sctor: After this certifice by the funeral director, t	atlon: To	28 Manner of Deal		28b. Time of Specify, M 28c. Time of Injury Mork?  M 28c. Time of North Mork?  M 1 Yes 2 No									
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	he Hospital or n 24 hours afte he Funeral Dir pletely filled in	Medical	29a. Certifier (Check only one)	Certifyir 2 Medical	Examiner: On the	the best of my basis of exa anner stated.	y knowledge, deat mination and/or in	h occurred at the ti vestigation, in my o	opinion, de	eath occurr	and due to th red at the time	a, date an	nd place, and di	ue to the cause(s)
	To the l	Σ	29b. Signature and		lich			29c. Licens	se number				ate signed (Moi	
-	(10)		30. Name and add	ress of person			(Item 23a) (Type,			77.0	20-8	-		
	Sta Regist		31. Date filed (Mor		04 132	. Registrar's	Signature	W	(R. a	7	000		<u></u>	

		1 - For State Registrar	State of M		Cei	rtificate of	Death		Reg. N		
Physicia /Medic		1. Decedent's Name (First, Middle Edwin Cecil St						2. Date of Month Apr		3, 2004°	3. Time of Dea
Examin		4a. Facility Name (If not institution, Chester River				4b. City, Town, Chest	or Location of ertown			Kent	)
Funeral Director		5. Social Security Number 221-07-5375	6. Sex 7. Ag 1 1 M 2 ☐ F	92 (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		4 Hrs. 8. Date of i Min. (Month, ADCLL	Birth 19 Yea	1911 9. Birth	plece (State or Fo intry) ryland
MO MI		Usual Residence of Decedent  10a. State 10b. County		10c. City	r, Town or Lo	cation					10d. Inside City L
one. then "natural", or items 23s or 28s-1 show the Mudical Examiner russi be mudified at	ctor	Maryland Queen	Anne's	Che	sterto	own					1 🗆 Yes 2 🗓
st te nu	al Dire	10e. Street and Number 307 Old Bridge R	oad			10f. Zip Code 2162	20		10g. C	Citizen of What Cou	untry?
Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show important: If Item 27 is marked other then "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner reast by nothing at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	?	1	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2∑ No		n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh	, etc.
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t, the	Com	4		3+)	machi	lnist				ber	
ed oth	Be	17. Father's Name (First, Middle, 1 Walter Linford S						s Name <i>(First, Midd</i> h Elizabe			d
mark	10	19a. Informant's Name/Relationsh			19b. Mailin	ng Address (Street		or Rural Route Nun			
n 27 is		Mary T. Stigile	/ Wife					l, Chester	-		
rtant: If Iter njury or oth		20a. Method of Disposition  1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.	ecify)	20b. Pl	ester	sition (Name of natory or other pla Cemetery	C	Date 04/17/2004	Che		, Maryla
any ir		21. Signature of Funeral Service I	Delfal	05	> Fe	allows. F 30 Speer	lelfent Road	ein & New Chesterto	mam own,	Funeral Maryland	Home P. 21620
9 sc		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each li	ine.	. Do not enti	er the mode of dyi	ng, such as ca	ardiac or respiratory			Approximate Interval Between
cian		Immediate Cause (Final disease or condition resulting in death)	b. Cheb Due to (or as  b. Cheb Due to (or as  cheone A Lu  C. Due to (or as	וקסו	el no.	nary 1	TRIVET	+			Onset and Deat
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Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):	latim					
hysicien and he burial-transit	calE		d. Hy		euses	in					
ang ph	Med	IF FEMALE:	000 16	-4							
been signed by the attending ph should be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of deliv Month	ery Day Year
signed by	d by Ph	Part II. Other significant conditio	ns contributing to death b	out not resu	Iting in the ur	nderlying cause giv	ren in Part I.			use contribute to t	
s peen s	Completed							24a. Wt		24b. Were auto	opsy findings avail
page 2	Comp							— aui pei 1 ☐ Yes	lopsy rformed? 2 ₽√	prior to co	empletion of cause
s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hoostel.					f Death (Check only			
n. After this funeral d	itlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury	28c. Inju	4 🗀 14urs	28d. Describ			(fy)
affer deati   Director: d in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of In	jury - At ho tc. (Specify	me, farm, stre	eet, factory, office		28f. Location City or 7	(Street a own, Stat	and Number or Run te)	al Route Number,
To the Funeral Completely filled	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best examiner: On the basis of and manner st	f examinat	vledge, death ion and/or inv	occurred at the til restigation, in my o	me, date and ppinion, death	place, and due to the occurred at the time	e cause(s e, date ar	s) and manner as s nd place, and due t	stated. o the cause(s)
To th comp	9W 4	29b. Signature and title of certifier	ested a	m. A		29c. Licens		9	29d. Da	ate signed (Month,	Day, Year)
		30. Name and address of person of Tolm ( ANNA)		death (Item	23a) (Type, I	Print) 1854 St	uet	q Chestan	Com	Hed ?	2/620
Sta	175	31. Date filed (Month, Day, Yeer)	32. Registr	ar's Signat	ure	1	-		-		
Registr	ar	ALK 1	6 2004	200	A.	Charles 3					

			1 - For State Ragistrar	State of Maryland		artment of H rtificate of L			jiene 2 (	004	and the second	718
A.	Physici /Medic		Decedent's Name (First, Middle, Last)     Phyllis Daphne Tol					2. Date of Dea Month April	20 2	Year 004	3. Time of 3:05	Death P M
	Examir Funeral	er >	4a. Facility Name (If not institution, give s 701 Glenwood Stree  5. Social Security Number 6. Sec.	et #620 7. Age (In yrs. I		4b. City, Town, or  An  If Under 1 Year  Months Days	Location of Dea napolis If Under 24 Hrs Hours Min	la Data d'Biat		Arur 9. Birthp	lace (State or	r Foreign
	Director		216-40-0166	02	Yrs.	peation		Nov. 12	, 1921	Enc	I and Od. Inside Cit	y Limits
	death with the Maryland me 23s or 28s-f ehow rmust be notified at	Director	Maryland Anne Arun			A) 10f. Zip Code	nnapolis		0g. Citizen of \		1 X Yes	2 🗌 No
36	be filed within 72 hours after death with the Marylan ital Hygiene. d other than "natural", or iteme 23a or 28a-f ehow event, I'ra Medical Exactinar must be notified at	Funeral	1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces?  1 Yes 2710 If Yes, Give	j	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	21401 ispanic Origin? (In, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	U.S  14. Rac Blac	e - Americ ck, White,		
1215-003	vithin 72 hours ne. hen "natural", e Medical Ex	Completed by	304Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: cation completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired ical Secre	during most of wo )	orking	16b. Kind of Bi	usiness/Ind	dustry	
Maryland 21	should be filed within and Mental Hygiene.  s marked other than "umatic event, I'm Me.	To Be Co	17. Father's Name (First, Middle, Last) Charles T. White	2	med.	icai seci	18. Mother's Na	me (First, Middle, fred Rose	Maiden Suman		re_	
	nd 2 salth ar 27 ls		19a. Informant's Name/Relationship (Type Malcolm Tolliver/			ng Address (Street a 2 Shenando					<sup>Code)</sup> 20119	)
altimore,	of High		20a. Method of Disposition 1 ☐ Burial 2/CCremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crer	esition (Name of matory or other place Cremato:		Date 23/2004	20c. Location - Baltim			and
Balti	permit. Pag Department Important: any injury o		21. Signatur uneral Ferrice License	", Lille	1	2. Name and Addres	_	John M. Ta	aylor F	unera	1 Home	2
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)	vy ec	dema voliony	g, such as cardia	c or respiratory arr	est,	4	Approximate Interval Betwoonset and D	veen Death US
x 68760,	leath certificate be executed attending physician and I for use as the burial-transit	icai	that initiated events resulting in death) Last	Due to (or as a consequ	10	c van	T CMS	w.se			20940	
.O. Box	0 0 0	by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna. 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Dai	e of delive	,	ear
Records, P	The law requires that the te has been signed by the hage 2 should be detache		Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	es 2 TNo		e cause of de	
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Division of Vital	ding Phys h. After this funeral di	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1   Inpatient 2   1   28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injury Work	er: 4 🗆 Nursing	eath (Check only on Home 5 eside 28d. Describe ho	ence 6 Oth		')	
Divis	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Si City or Town		er or Rura	Route Numb	er,
	the Hospital in 24 hours a the Funeral I pletely filled	edical	(Check only 2 Medical Examin	nar: On the best of my known nar: On the basis of examinat and manner stated.	wledge, death ion and/or in	vestigation, in my of	oinion, death occ	urred at the time, d	ate and place, a	and due to	the cause(s)	
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	vise Rean	MO	29c. License	number 7H97	2	9d. Date signed	21 <sup>50</sup>	200 F	+
			30. Name and address of person who con Beau, Bay bar a	mpleted cause of death (Item Swt 310,	23a) (Type,	Print) Print)	al Par	Mulay.	Arria	Dol	5	
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 2 20	32. Augistrar's Signat	ture	Coul 1				1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001, 14719 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** April 2004 1840 Renee Monique Taliaferro /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Min 1 ☐ M 2 2 F Months Hours Yrs. Director 214-94-8134 Sept. 16, 1959 Maryland 44 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow 10a State 10b. County 1 ∰Yes 2 No Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code s 23a or United States death ! 616 Admiral Drive #368 21401 Funeral or Items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white the Medical Exam þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry event. If a Mo Elementary/Secondary (0-12) College (1-4or 5+) 10 unemployed 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) Be Edward Taliaferro Renee Florence Camille Hunt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Edward Taliaferro, III/ brother 45 Blockbouse 3d. Willsboro, NY 12996 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 @Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 4/24/04 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) days **Physician** /Medical Due to (or as a consequence of) **Examiner** Cholegystitis days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality for as a consequence off Examine The law requires that the death certificate be executed ng physician ar Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ been signature should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

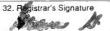
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page certificate 1 ☐ Yes 2 No or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours at To the Funeral D completely filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D46052 4/22/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sjokrol Blik, MD 2001 Medical Medical Pourkney annaphy, MD

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. R





# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

			1 - For State Unpend Item #23	a,27,28a-f per	me 6831 5/	25/04 tas tificate of	Death	nemai riy	Reg. No.	UL	14	/20
	Physici	an	1. Decedent's Name (First, Middle, Li	ist)				2. Date of Dea Month	ath Day	Year	3. Time of	
	/Medic		Leland Floyd Th					April	16, 2004	4	456	a <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, gi	,	1.0		Location of Death		4c. County			
3			10000 Brunswick  5. Social Security Number 6.		18 n yrs. last birthday)	SIIVE.	r Spring  If Under 24 Hrs.	I a Data of Bird	Monte			
9	Funeral Director		540-12-9070 Usual Residence of Decedent	1⊠M 2□F 8		Months Days	Hours Min.	8. Date of Birth (Month, Day Oct. 28	, Year) 3, 1919	Idah	lace (State o itry) 10	or Poreign
	land ow		10a. State 10b. County	10	C. City, Town or Lo	cation				1	0d. Inside Ci	ity Limits
	Man F-f sh	tor	Maryland Montgon	nerv	Silver S	nrino					1 🗌 Yes	2 🙀 No
	h the or 28;	lred	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?	
	23a c	alD	10000 Brunswick	Avenue, #618		20910			U	SA		
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Eve. Armed Forces?	r in U.S. 13. \	Vas Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Raci	e - Americ		
960	ours afte ral', or li Ezamin	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: W		I⊡Yes 25xx No				Whit		
5-0	"natu	Completed	15. Decedent's 8 (Specify only highest gi	ducation a de completed)	16a. Deced (Give	lent's Usual Occup kind of work done	ation during most of work f)	ing	16b. Kind of Bu	siness/Ind	lustry	
121	within ane. than	dw	Elementary/Secondary (0-12)	College (1-4or 5+)			1)		D	<b>.</b>		
d 2	filed Hygie thar		17. Father's Name (First, Middle, Las		Disp	layman	18. Mother's Name	e (First, Middle.	Retail Maiden Sumam		es	
an	id be ental ked o c eve	To Be	Floyd Christia					etrisha		•		
Z	should Mark	-	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street	and Number or Run				Code)	
<b>≥</b>	nd 2 alth a 27 Is		Susan L. Bloom	/ Daughter			Court, O				,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-1 show among youry or other traumatic event, it is Medical Examinar must be notified at Once.		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 [	Removal from State	20b. Place of Dispo	sition (Name of natory or other plac	a) Apri	L 19,	20c. Location -	•		1
altin	mit. Poartme		* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Pa:	rk	ss of Facility Collins		Rockvil		laryla	nd
ä	an per		→ Unchew	7 Cole		0 Univer	sity Blvd	. W., S	ilver Sp	nc. oring		
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ari	rest,		Approximate Interval Bety Onset and E	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Multiple In	juries							
	Examiner			Due to (or as a co	onsequence of):							
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	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	an an rial-tr	Exa	resulting in death) Last	Due to (or as a co	onsequence of);							
68760,	death certificate be executed a attending physician and d for use as the burial-transit	Medical	•	_ d	_							
	5 a	Med	IF FEMALE:							1		
Вох	ne death ce the attendii hed for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Date Mor	e of delive	-	/ear
P.O.	the de	Physician/	1 Tes 2 No	4□Pregnant at time 9□ Unknown	e of death 5L	Other (specify)					,	
	that the ned by th detache		Part II. Other significant conditions	contributing to death but no	ot resulting in the ur	iderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to the	e cause of de	eath?
Division of Vital Records,	w requires that the de been signed by the should be detached	d by						1 🗆 Y	es 2 🗆 No	3 🗌 Proba	ably 4 💢 U	Jnknown
00	s bee	Completed						24a. Was a	ın 24b. V	Vere autop	sy findings a	available
æ	ysician: The lar is certificate has director, page 2	om						autops perform 1 127 Yes	med? d	rior to com eath? LaYes	npletion of ca 2□ No	ause of
ita	ian: rtifica ctor. p	Be C	25. Was case referred to medical				26. Place of Death		/	103	2 140	
<b>5</b>	Physician: this certific ral director.	70 E	examiner? 1   Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 □ DOA Othe	er: 4 🗆 Nursing Ho	me 5 🗆 Reside	ence 6½0the	r (Specify	at so	cene
٥			27. Manner of Death  1 Natural 5 Pending	Found th, Day Ye	ear) 28b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	ow injury occurre	ed		
Si Si	Attanding r death. actor: After oy the fune	catl	2 Accident investigation 3 Suicide X Could not be	4/16/04	4.40	A	_	Inknown				
Ξ	or At offer of Diract in by	Certification:	4 Homicide	building, etc. (S	ipecify)	et, factory, office		28f. Location (Si City or Town			Route Numb WICK AV	venue
	pital burs a eral (		202 Certifier 1 Certifying B	Found in n				Silver Spr				
	To the Hospitel or Attence within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☑ Medicel Exe	hysicien: To the best of mainer: On the basis of exa and manner stated.	y knowledge, death amination and/or inv	estigation, in my or	pinion, death occurr	ed at the time, d	ause(s) and mar ate and place, a	ner as sta nd due to	the cause(s)	)
	To the within Fo the comple	Me	29b. Signature and title of certifier	,		29c. License	number	2	9d. Date signed	(Month, D	ay, Year)	
	1		17/10/11	1 /		001	ΜE		April 1	16, 2	004	
	•		30. Name and address of person who	completed cause of death	(Item 23a) (Type, I	Print)						
_			THEODOREL	liking		111 Per	nn Street	, Baltir	nore, Ma	ryla	nd 212	201
\ <b>I</b>	Sta		31. Date filed (Month, Day, Year) APR 1 9 20	32. Registrar's S	Signature	Par is	,					
/	Registr	ar	APR 19 20	UT MARKET	fed	Sparks	ed a					

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year April 18, 2004 12:00 pm Francis Xavier Thornton 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth <u>Rockville</u> Montgomery Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Deys Hours Months 1⊠M 2□F 91 Dec. 5, 1912 New 060-09-8906 York Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 20852 USA 6624 Sulky Lane 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 ☑ No f Yes, Give 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Yeer or Dates 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Publishing/ Printing Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth McNulty Joseph Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6624 Sulky Lane, Rockville, MD 20852 Marie K. Thornton/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Alexandria, Virginia Metropolitan Crematory 22. Name end Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee nohew 500 University Blvd. W., Silver Spring, MD 20901 Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death THROMBOSIS Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? ERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

Physician /Medical Examiner Examine

led by the attending physician end deteched for use es the buriel-transit

certificate has been significator, page 2 should be

within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director, i

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Hospital or Attending

by Physician/Medical

Completed

Be

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Medicai Certification:

Division of Vital Records, P.O. Box 68760.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

7 is marked other traumatic event, I

Item 27 i

Depertment of important: if it any injury or conce.

Funeral Directo

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Completed

Be

Peges 1 end 2 should be filed within 72 hours after death with the Meryland nent of Heeith end Mentel Hygiene.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

Hospital: 1 ☐ Inpatient

28e. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be determined

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Mannier of Death

1 Naturel 2 Accident

3 Suicide

4 ☐ Homicide

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name an completed cause of death (Item 23e) (Type, Print)

MID

32. Registrer's Signature

TROSE RD FECKULCES LD 20852

HPRIL 19,2004

State Registrar

**DHMH 16 Rev 6/95** 

			For State Registrar	State of	Maryland /	Depa Cer	artment o	of He	ealth a Death	nd M	ental Hy	giene		14	722
		ş.	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month			3. Time o	Death
	Physici /Medio		Catherine W.	Tocha							April			1:41	рм
10,	Examin		4a. Facility Name (If not institution,	give street and num	nber)		4b. City, To	wn, or l	Location of	Death		4c	. County of Death		
			Washington Adv						Park				Montgom	ery	
4	Funeral			5. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last b		If Under 1 Months E	Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Di	rth a <i>y, Year)</i>	9. Birth Cou	pface (State ontry)	
	Director		070-09-0974		91	Yrs.					May 26	, 19	12 New	York	<u> </u>
	and w		Usuaf Residence of Decedent  10a. State 10b. County		10c. City, To	wn or La	cation							10d. Inside C	ity Limits
	Manyl 1 • hc	ō	Manual und Mantaga		C41.		Cnwine							1 🗌 Yes	2 (X)No
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	me 2:	Funerai	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. \			spanic Orig	in? (Spe	cify Yes or No Rican, etc.)		14. Race - Amer	ican fndian,	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "natural", or fleme 23a or 28a-f ehow raumatic event, the Madical Examiner rust be notified at	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed For d 1 Tes If Yes, Give Year or Da	2 [X] No 9	1	f Yes, specify 1 ☐ Yes 2			Puerto I	Rican, etc.)		Black, White Specify: White		
Maryland 21215-0036	2 hou	ted	15. Decedent's		16	a. Deced	lent's Usuaf (	Occupat	tion			16b. K	ind of Business/Ir	ndustry	
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a	2 sho and h is me		19a. Informant's Name/Relationship	o (Type, Print)	19	b. Mailir	ng Address (S	treet ar	nd Number	or Rura	l Route Numb	er, City o	or Town, State, Zi,	p Code)	
	1 and 2 Health tem 27		Robert Tocha/	Son					Stre	eet,	Silve	r Sp	ring, MD	20901	
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□ Domoval from 9	cemet	ery, cren	sition (Name natory or othe	er place,	) ! /	Apri	1 20,	20c. Lo	ocation - City or T	own, State	
Ĕ	Pages Internal of I		'4 □Donation 5 □ Other (Spe		Gate	of	Heaver	n	1	20		S11:	ver Spri	ng. MD	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke any injury or other traumatic once.		21. Signature of Funeral Service Li	censee Coo		22	. Name and A							C) / TO C ( ) C	
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н			23a. Part1. Enter the disease, or conshock, or heart failure. List of	olinplications that ca nivone cause on ea	used the death. Do ich line.	not ent	er the mode o	of dying,	, such as c	ardiac o	r respiratory a	rrest,		Approximat Interval Bet Onset and	ween
	Physician		Immediate Cause (Final disease or condition	-a. GAN	grava a consequence	D	F G	94	-131	pol	Ser	-		24 11	کرسد ک
В	/Medical Examiner		resulting in death)	Due to (A	r as a consequence	e of):	7			0					,
Н	70	er	Sequentially list conditions, if any, leading to immediate	b. Kup	or as a consequence	(2	ALLI	36	add	سارت				24 H	our
	led nsit	nine	cause. Enter Underlying Cause (Disease or injury	0:00	or as a consequence		0	Mar-						0.1	,
	and all-trar	Examin	that initiated events resulting in death) Last	c. Due to (	or as a consequence	e of):	ERIJE	NI	115					X4 /13	Jur
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X	The law requires that the death certificate be executed to has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregnancy								23d. Date of deliv	en/	
m	leath atter	ciai	in the past 12 months?		rth 2 Fetaf deal ant at time of death		Ectopic pregr Other (speci						Month		Year
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ā		e C	25. Was case referred to medical	RAX	1067				06 Bl	-1 Dooth	1 Yes		1 ☐ Yes	2□ No	
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ō	Phy or this oral d	$\vdash$	27. Manger of Death	28a. Date or (Month		Time of		Injury a Work?	4   IAUIS		8d. Describe		6 □Other (Specif v occurred	Y)	
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Division	or Attendi after death. Director: A in by the fu	ifica	3 Suicide 6 Could no	ed 286. Place	of Injury - At home,	farm, stre	et, factory, of	ffice		2	8f. Location (	Street an	d Number or Rura	al Route Num	ber,
á	a after	Certification;	4  Homicide	buildin	g, etc. (Specify)		,				City or To	wn, State	)		
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the l	best of my knowledgesis of examination a	ge, death	occurred at t	he time	, date and	place, a	nd due to the	cause(s)	and manner as s	tated.	
	the H in 24 the F nplete	Medical	une)	and mann	er stated.	410201 1119				occurre	o at the time,				)
	S T S	-	29b. Signature and title of certifier	11-8	Ann- M	90			number				e signed (Month,		
•	12		20~	7/27-1	4		D	410	033			4/-	16.09		
			30. Name and address of person w	no completed cause	of death (ftem 23a	(Type, I	Print)				7		16.04	20%	707
			DR SARABJ	11 5.	ANANA,		4301	1	AUIO	-/ 1	nrk.	1)K	- , LAM	56,1	200 .
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Examir Funeral	ier	Upper Chesapeake  5. Social Security Number 6. Secu	Medical Ce	In yrs. last birthday,	Be1	Air Year If Under	24 Hrs.	8. Date of Bir	На:	rford 7 9. Birtho	ece (State or Foreigi
Director		Usual Residence of Decedent	<b>(</b> M 2□ F	87 Yrs.		Pays Hours	Min.	(Month, Da	1917	Nort	Carolina
e Marylar sa-f show	Director	10a. State 10b. County Florida Volusia	1	Oc. City, Town or L Dayto						1	0d. Inside City Limits 1   Yes 2  No
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72 hours alter death with the Maryland natural', or items 23a or 28a-f show lical Examitter cust be rediffed at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	1942-	Was Decedent If Yes, specify 1 ☐ Yes 2 ☒	t of Hispanic Or Cuban, Mexical No Specify:		cify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: B]	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic evant. In Maralcal Examitrat must be realified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual O kind of work of DO NOT use r	lone during mos etired)	st of workin	g		al Gov	dustry Vernment
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Dermit. Pages 1 ar Department of Hea Important: If Itam Iny injury or other		1	emoval from State	Gate of I	matory`or other Heaven	r place)	4/15/	04	Silver	Sprin	g, MD
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Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Pulmon  Due to (or as a c	ary Embol	Lus						Interval Between Onset and Death 1 year
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The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of a 1	Fetal death 3	Ectopic pregn					Date of delive Month	ry Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but n	not resulting in the u	nderlying caus	e given in Part I.					e cause of death? ably 4 □Unknown
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for Attending Physician: The law requires tatler death. Diractor: After this certificate has been signe tin by the funeral director, page 2 should be come.	tion; To Be	25. Was case referred to medical examiner?  1  Yes	ospital: 1  Inpatient 28a. Date of Injury (Month, Day Ye	2 (XER/Outpatier 28b. Time of Injury	28c.	04	rsing Home	Check only of a 5 Resid	ence 6 🗆 C		)
To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, str Specify)				If. Location (S City or Tow	itreet and Nui n, State)	mber or Rural	Route Number,
To the Hospital or within 24 hours at To the Funeral Di completely filled in	edical	29a. Certifier 1 Kertifying Phys cone) 1 Medicai examir	sician: To the best of m ler: On the basis of ex and manner stated	amination and/or in	n occurred at the	ne time, date and my opinion, deat	d place, an th occurred	d due to the o	ause(s) and date and plac	manner as sta e, and due to	ited. the cause(s)
2+(	×	29b. Signature and title of certifier	~			0721676			_	ned <i>(Month, E</i>	
1.		30. Name and address of pers n who co Kevin Madtes, M	mpleted cause of deat	h (Item 23a) (Type.	Print\			1			110000

		1 - For Stete Registrar	State of Maryland	/ Depa	rtment of F	lealth and Death		Reg. No.	104	14724
Physic /Med		1. Decedent's Name <i>(First, Middle, Last)</i> Anna Mae					2. Date of De Month April	Day 2.0 (	Year ) 4	3. Time of Death 9:55 pM
Exam Funera Directo	iner	4a. Facility Name (If not institution, give s  Genesis Elder C  5. Social Security Number  6. Sex		k- st birthday) Yrs.	Annano If Under 1 Year Months Days	Hours Min.	8. Date of Bir	4c. County Anne rth ay, Year) 8 1924	Arun 9. Birthpl Coun	ndel lace (State or Foreign try) Vland
		216-18-6290 Usual Residence of Decedent  10a. State 10b. County		Town or Lo	cation	<u> </u>	APLII Z	0 1924		Y Land Od. Inside City Limits 1  Yes 2 □ No
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was 23a or 28a-f show other traumatic event, the Medical Eparamet must be notified at	rai Directo	Maryland Anne Ar 10e. Street and Number 1211 Shesley Ro	na d	apoli	10f. Zip Code			10g. Citizen of	US	atry?
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Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the death. ne cause on each line.	Do not ente	21 West or the mode of dying the mode of dying the mode of the mod	St. Ar	nanoli c or respiratory a	S, Md.	21/40	Approximate Interval Between Onset and Death
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thin 24 ho the Fune of the Fune	Medicai	29a. Certifier (Check only one)  2 Medical Examination  29b. Signature and title Acertifier	sicien: To the best of my knowl ner: On the basis of examinatio and manner stated.	edge, death on and/or inv	restigation, in my o	pinion, death occi	e, and due to the arred at the time,	cause(s) and madate and place, 29d. Date signe	and due to	the cause(s)
¥ × × 00		30. Name and address of person who co	ompleted cause of death (Item 2	23a) (Type	\$ 32	036		4/161		
S	tate	Gary J. Sor	32. Registrar's Signatu	D on al	o Orive	Chil	v. ~0 3	1619		
Regis		APR 197	2004	A.S.	Caesas)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 0130 4 AVon eat APRI James /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner P; +a1 7. Age (In yrs. last birthday) MX Yrs. Easton
If Under 1 Year If Under 24 Hrs. Talbot Vienoria HOS 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 100 M 2□F Days Min. 218-20-334 Director Mari May Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Exeminer must be notified at 1 DYes 2 No Easton by Funeral Directo Talhot 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 201-23a 21601 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 No 1945 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 PNo 3 DWidowed 4 □ Divorced Black "naturel" Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) tactor! Warehouseman anning of Health and Mental Hygie fitem 27 is marked other to try other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Fton HORRIS Teat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Cour+ baltimore. ERIKA 1110 VERANDA MD 21226 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - ity or Town, State Important: If it 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 23/04 HURIOCK, Maryland Veterans Cemetery permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, 516 Washington St. a washington St. Cambri MD,2/6/3 Part1 Enter the disease, or complications that shock, or heart failure. List only one can on Approximate Interval Between Onser and Death used the deat Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months
1 Yes 2 Who Day ed by the a 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be o 1 7 Y6s 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 NO 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Dther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Box 68760. Records. Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifie 29c. License number

State

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carolyn Helmly, M.D., 503 Cynwood Drive, Easton, MD APR 21

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1:28 PM 10wn send 2004 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Howard Country General If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. Howard 5. Social Security Number 6/Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 577-88-4204 Usual Residence of Decedent 1 □ M 2 F Yrs. June 12,1959 virginia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? outhern 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government ecretari 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Shirley William Henry Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3810 Southern Ave, # 12 SE, Washington, DC 20020 Shirley Boyd 20b. Place of Disposition (Name of cometery, crematory or other place)

Bethel Lemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State April 10,2004 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Creene Funeral Home, INC. Malon E SI4 Franklin Street, Alexandria, UA 22314 Jum Approximate Interval Between Onset and Death 415

23d. Date of delivery

Dav

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

Year

Physician /Medical Examiner

and

signed by the attending physician

Physician

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

or Items 23a

"natural",

Director

Completed by Funeral

Be

other traumatic event, it a Medical Examiner must be notified at

filed within 72 hours after deeth with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "ne any injury or other traumatic event, Its Medie 900. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) benign brain tumors with a. Multiple Due to (or as a consequence of (un resectable herniation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 — Yes 2 — No 3 □Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signarune and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD, FCCP D36845 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) Pai-Chi Nguyen, M.D. FCCP

or Attending Physician: The law requires that the death certificate be executed

s after death.

within 24 hours a To the Funeral C the Hospital

P.O. Box 68760.

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year) APR 2 0 2004

7350 Grace



**ORIGINAL** 

			1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of Hertificate of D	ealth and I Death		iene 20	04 1472
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dear	th	3. Time of Death
	/Medi	cal	Lizzie J. To 4a. Facility Name (If not institution, give s			45 Oils Taura and	t and the of Death	April	7, 2004	5:20 A M
Ĉ.	Examir	ier	Springbrook Nursing		itation	4b. City, Town, or Silve	er Sprin		4c. County of	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9	Birthplace (State or Foreign Country)
	Director		098-20-8327 Usuel Residence of Decedent	M 2AJF 77	Yrs.			April 14	4, 1926	South Carolina
	yland		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f sl	Director	DC N/A		Washingto	on, DC				1 <b>X</b> Yes 2 □ No
	with the	Dire	10e. Street and Number	N 17		10f. Zip Code	2011	1	0g. Citizen of Wha	at Country?
	be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or itams 23a or 28a-1 show event, the Mediral Examiner must be resulted at	Funeral	5336 Colorado Ave.	12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of His f Yes, specify Cuban	0011 spanic Origin? (S	pecify Yes or No-	USA 14. Race -	American Indian,
9	or its	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give		fYes, specify Cuban I□Yes 257No	Specify:	o Rican, etc.)	Bleck,	White, etc.
215-0036	hours tural',	ed by	Widowed 4 □ Divorced	Year or Dates:						B1ack
<u>ن</u> 15	nin 72 In "na	plete	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	lent's Usual Occupat kind of work done du DO NOT use retired)	uring most of wor	king	16b. Kind of Busir	ness/Industry
	filed will Hygiene other tha	Completed	10th	College (1-4015+)	Но	usewife			Pvt	•
and	be file	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	Maiden Sumame)	
Maryland 2	2 should be and Menta Is marked aumatic ev	ဥ	Unknown  19a. Informant's Name/Relationship (Typ	ne. Print)	19b Mailin	g Address (Street ar		Meyers	City or Town Sta	ata Zin Cada)
	s 1 and 2 should if Health and Men item 27 is marks other traumatic		Joseph V. Jackson/		£.	Longfeat				
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		b. Place of Dispo	sition (Name of natory or other place,			20c. Location - Cit	
Ē	t. Pages rtment of rtant: If it		*4 □ Donation ♣ □ Other (Specify)	F		Cremator		14,04	Riverdal	e, MD
Ra	permit. Page Department of Important: if any injury or once.		21. Signal red Funeral Service License	anh	Jo	Name and Address  hnson & C  Kennedy	Jenkins	Funeral H	Home, Inc	0011
			23a. Part . Enter the disease, or complice shock, or heart failure. List only on	cations that caused the ce cause on each line.	death. Do not ente	er the mode of dying,	, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CAR	DIOP	Ulmona	vy A	rrest		Onset and Death
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	, A' 8	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co		7	9 0			
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8/00,	ficate be executed physicien and s the burial-transit	caiE		Due to (or as a con	sequence or): —					
200	ifficate g physas the	찟	d.							
žož	death certifi a attending p	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Sc. If yes, outcome of pre		Ectopic pregnancy			23d. Date of	,
5		ysici	1 Yes 2 No	4□Pregnant at time 9□Unknown		Other (specify)			Month	Day Year
7.	requires that the de een signed by the a nould be detached t	y Physi	Part II. Other significant conditions conf	ributing to death but not	resulting in the un	derlying cause given	in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
ecords		ed by						1 □ Ye:	s 2□No 3□	Probably 4 Unknown
) 1)	× 0 2	ompleted						24a. Was an		e autopsy findings available
r	The ate h page	Com						autopsy perform	ed? deat	r to completion of cause of h? Yes 2□ No
VII	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:		Other		h (Check only one		
5	g Phys er this eral dir	-	1 ☐ Yes 20€No Pro	28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 DOA 28c. Injury a Work?	4 Nursing Ho	ome 5 Resider 28d. Describe how		Specify)
VISION	anding lath.	atlo	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury		s 2 🗆 No			
<u> </u>	or Atten ifter deat Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	r Rural Route Number,
_	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	cian: To the best of my	knowledge, death	occurred at the time,	, date and place,	and due to the cau	use(s) and manne	r as stated.
	the H hin 24 the F mplete	Medical		er: On the basis of exam and manner stated.	ination and/or inv					
)	<b>5</b>		29b. Signature and title of confifier	Ker AN		29c. License r	number	29	d. Date signed (M	Ionth, Day, Year)
0	(1)		30. Name and address of person who con	nplefed cause of death (	) Item 23a) (Type: F	Priori)	071	N	MILLI 1	5, 2004
	(3)		31. Date filed (Month, Day, Year)	Ma T	7325A 7	Jambuer	tarku	ly Creen	belt 1	Maryland
	Sta Registra		ΔPR 2 1 2004	32. Registrar's Si	y rature			1		/

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner STEP If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 114/1908 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 💢 F 96 ESTONIA 214-32-3840 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show Examiner must be notified at MD. CITY 1XX es 2 ☐ No BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itams 23a 3215 CLIFTMONT AVE. 21213 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural", or Itas any injury or other traumatic event, its Medical Examinat 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY OFFICE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BINSOL MIHKEL MARIE ROSA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VELLO VOLAR - SON 600 POOLE RD., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ALL COUNTY CREMATION 4/19/04 SYKESVILLE, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Signature 9 once. 254 E. MAIN ST., WESTMINSTER, MD. Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** ementa disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Stenusis and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the attending physician echhiths M Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deal 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, g 3 Probably 4 Unknown 1 ∏Yes 2 ∏No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? this certificate 1 Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending To the near after death.

You the Funeral Director: After the funeral bird in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-005 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Raman malcalm dure Kaneig 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2001

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	Physic /Medi		AUGUSTA Y.	VADER						APRIL	14,2004	Year	12:40 AM
*	Exami		4a. Facility Name (If not institution, give						4b. City, Town, or	Location of Dea		y of Death	
			HEBREW HOME OF GRE	ATER WAS	SHINGT	ON		F	ROCKVILLE		MONTG	OMERY	
	Funeral		5. Social Security Number 6. S	9x 7. □M2⊠F	. ,	last birthday)	If Unde Months	r 1 Year Days	If Under 24 Hrs Hours Min	8. Date of B	irth Day, Year)	9. Birthp	place <i>(Stat</i> e o <i>r Foreign</i> http: http://www.ny
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	pur *		Usual Residence of Decedent  10e. State 10b. County		10c Ci	ty, Town or Lo	cation						Od Incido City Limits
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	eath	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U	S 121	Mac Door	2085		Specific Veca er N		ed St.	
_	ter d Itam	Ę	1 Never Married 2 Married	Armed Force	s?	,5.	f Yes, spe	ecify Cub	li <i>s</i> panic Origin? (S an, Mexican, Puer	to Rican, etc.)	Bla	ick, White,	
20	filed within 72 hours after death with the Maryland Hygiene. that than "natural", or Itams 23a or 28a-f show ant, the Medical Examiner must be incitited at	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1□Yes	2'⊠ No	Specify:		Specia	fy:	White
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b	otha vant	Be	17. Fether's Name (First, Middle, Last)						18. Mother's Na	me (First, Middle	e, Maiden Surnai	me)	
/la	should be and Mentel is marked o	70	Ferdinand Yanke						Julia	ı Babe	ecki		
Baltimore, Maryland 21215-0020			19a. Informant's Name/Relationship (7						and Number or Ru				
≥ `			David G. Vader /	Son		1973	2 Mer	redit	th Drive,	Derwoo	od, Md.	2085	5
ore	es 1 an of Healt itam 2 r other		20a. Method of Disposition 1 ☐ Buriat 2 ☑ Cremation 3 ☐	Domeyal from Ch		Place of Dispo	sition (Ne	me of other place	ce)	Date	20c. Location	City or To	wn, State
Ĕ	permit. Pages 1 an Department of Heal Important: if itam 2 any injury or other	1 7	4 □ Donation 5 □ Other (Specify		™ Me	tropol	itan	Cren	natory	4/14/04	Alexa	ndria	, Va.
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus	sed the deat	h. Do not ente	er the mod						Approximate
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387	phys the	얼	thet initieted events resulting in death) Last		Due to (o	r as a consequ	uence of):						
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ă	atter atter I for u	ciar								-			
P.O.	y the	Physicia	Part II. Other significent conditions co				nderlying o	cause give	en in Pert I.				the cause of death?
σ,	requires that the death	by Pi	CHRONIC RENAL	. 1NSUFF1	LCIENC	Υ				10	Yes 2⊠ No	3 □ Prob	ably 4 □ Unknown
rds	uires n sign	D D	ALZHEIMER'S D	EMENTIA						24a. Was	en eutopsy	24b. We	re autopsy findings
8		lete	ALZHEIMER 3 L	LILLIA						perfe	ormed?	con	allable prior to
æ	The law rate hes by page 2 sh	Completed									Yes 2⊠TNo		death?
ta	ician: The certificate rector, pag	au I	25. Was case referred to medical						26. Place of Dea				]Yes 2□No
<u> </u>	Physician: ' r this certifica	To B	examiner?	Hospital:	itient 2□	ER/Outpatien	1 3 D	OA Othe			idence 6 □Oth	or (Specify	
0	a Physeral		27. Manner of Death	28e. Dete of In (Month, I		28b. Time of		28c. Injun Worl	, and it was only in		how injury occur		/
<u>ō</u>	Attanding r death. actor: After by the fune	atio	1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, L	Jay rear)	Injury	М		Yes 2 □ No				
Division of Vital Records,	Atta er de acto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	Injury - At ho	me, farm, stre	et, factor	y, office		28f. Locetion ( City or To	Street and Numb	er or Rurei	Route Number,
۵	safter sa	Ce		building,	etc. (Opecii)	7				Only or 10	wii, Olale)		
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	edicai	29a. Certifier 1 Certifying Phy. (Check only 2 Medical Exam)	alclan: To the bes	of examine	vledge, death	occurred	et the tim	ne, date and place	, and due to the	cause(s) and ma	nner as ste	ated.
	tha thin 24 tha F		one)	and manner	stated.	with of the							
	o Territor	Σ	29b. Signeture and title of certifier	in la			290	c. License			29d. Date signed		ley, Yeer)
	3			Dilons				D 00	057884	5	4/14/01	1	
	-		30. Name and address of person who					u cT	DOCKA		2001		
			DAMIEN J. DOYLE,						., ROCKVI	LLE, ML	208!	٥٧	
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Hegis	strar's Signa	La La	hou	reter	/				

State of Maryland / Department of Health and Mental Hygiene 2001

					Certifi	icate of	Death			Reg. No.	004	L	136		
		1. Decedent's Name (First, Middle,	Last)						2. Dete of De	eth		3. Time of	of Death		
	Physician	Dorothy Bri	tt Vann						Month April	13 2	1004	11:	58AM		
, J	/Medical Examiner	4a Fecility Name (If not institution,	give street end numb	er)			4b. City, To	own, or Lo	cation of Deat		ty of Deeth		JOINT		
	Zammer	Holy Cross Re	hab. & Nu	rsing Cen	ter		Bur	tonsv	7ille	M	lontgo	merv			
	Funeral	5. Social Security Number 6		Age (In yrs. lest bii		Under 1 Year		24 Hrs.	8. Date of Bir	th		place (State o	or Foreign		
	Director	223-16-0241	1□ M 2√2 F	83	Yrs.	onths Days	Hours	Min.	Jan. 1	6, 1921	Sout	h Caro	olina		
4.	4	Usuel Residence of Decedent	1												
	nylan	10a. State 10b. County		10c. City, Tow	n or Locatio	n					1	0d. Inside C	ity Limits		
	Ma To	Maryland Mo	ntgomery			Silver	Spri	no				1 ☐XYes	2 □ No		
	or 28s-1 s or 28s-1 s be notified	10e. Street end Number				Of. Zip Code				10g. Citizen of	Whet Cour	itry?			
	h wii	3504 Olive Bra	nch Dr.				20904	4		Uni	ted S	tates			
	ifter death v r ftems 23c niner mutt Funerai	11. Marital Status	12. Was Decede	ent Ever in U,S.	13. Was	Decedent of	Hispanic Or	igin? (Spe	ecify Yes or No Rican, etc.)		ce - Americ	an Indien,			
0	after Property	1 ☐ Never Married 2 ☐ Married	I 1 ☐ Yes 2			res 2∐XNo			nican, etc.)		ack, White,				
21215-0020	n 72 hours after death with the Manyland "natural", or flems 23a or 28a-1 show safeal Examiner must be notified at leted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:	'-	res ZLAINO	Specify:			Speci	ry: WI	hite			
5 0	led within 72 ho ygiene. Per than "natura nt, the Medical I Completed	15. Decedent's (Specify only highest)	Education	16a	Decedent's	s Usual Occu of work done	pation	t of working	na	16b. Kind of E	3usiness/Inc	Justry			
7	within :	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. DO N	IOT use retire	ed)	K OF WOTKE	ng .						
7	w bd will be a series of the s		6		S	ocial	Worke	r		City o	f Ric	hmond	• VA		
p	d oth Sent	17. Fether's Neme (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle,	, Maiden Surna	me)				
Maryland	Ment Ment arked	John Britt						F	lattie	Boatrig	ht				
and a	short short	19a. Informant's Name/Relationship		19b	. Mailing Ad	ddress (Stree	t and Numb	er or Rura	l Route Numb	er, City or Town	n, State, Zip	Code)			
Σ	alth alth	Anthony Vann	- Son		3504	Olive	Branc!	h Dri	ive, Si	lver Sp	ring,	MD 2	20904		
altimore,	other other	20e. Method of Disposition		20b. Place o	f Disposition	n (Name of ry or other pla	ice)		Date	20c. Location	- City or To	wn, State			
Ĕ	Pege Tr:≕ Tyou	1 □XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		ite	2007	wn Cem		1/4 /	17/04	Diah	mond,	7.7.A			
Ħ	nit. orta	21. Signature of Funeral Service Lic		1010	-	me and Addre				uneral		VA			
ŭ	permit. Peges 1 and 2 should be filed within 75 Department of Health and Mentel Hygiene. Important: if them 27 is marked other than "na any Injury or other traumatic event, the Medionce.  To Be Complet	N T	to -	1	3.6					Wash.,		019			
		23a Part 1 Inter the disease or or	A CONTROL	X down Do	_		_				DO 20		•		
and the same	150	23a. Part1. Enter the diseese, or co shock or heart failure. List on	ly one cause on eac	h line.	not enter the	o mode or dy	ng, such as	Carulac O	i respiratory a	ilest,	1	Approximate Interval Bet Onset and I	tween		
1	Physician /Medical	Immediate Cause /Final	d								1	1	,		
	Examiner	Immediate Cause (Final disease or condition resulting in death)										1 we	elc		
	- T	Due to (or as a consequence of):									mant				
	Sertificete be executed ding physician and se es the buriel-transit // Medical Examiner		b	una	11	17.60	110	1				NO	176		
	certificate be executed ding physician and see as the buriel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	1/0	Due to (or as e	consequenc	e of): /		1	er.		İ	1			
68760,	sicial Suri	Cause (Disease or injury that initiated events	c. Va	5001	ar	Rei	nes	17	19		16	xea	10		
89	icete phy s the	resulting in deeth) Last	D	Due to (or as e o	consequenc	e ot):					1	1.10	1.		
			d. In	eum	0011	9					1	We	2/4		
ă	v requires that the death of the etten should be detached for unshould by the etten should by Physician								1						
o	the d	Part II. Other significant conditions	contributing to deati	n but not resulting if	n the underly	ying cause gr	ven in Part I			tobacco use co					
Division of Vital Records, P.O.	that ned b deta	INPEZ	0196	et c5					1 🗆	Yee 2 No	3 ∐ Prob	abty 4□	Unknown		
g .	d b	' / 1							24a Wes	en autopsy	24b. We	re autopsy f	findings		
Ö	req beer shou								perfo	rmed?	ava	ilable prior to npletion of c	to		
ě.	The law requires the law requires the law been single 2 should Completed								25,000,000	Other PRESENCE	of c	death?			
e 1	Cate Cate								101	res ZIENO	1	Yes 20	No		
	clan entific ector	25. Was case referred to medical examiner?	Hospital:			04			(Check only o						
5	hysic this c al dire	1 Yes 2 No	1 Linps	atient 2 ER/Ou		LI DOA				dence 6 □Ott		)			
<u> </u>	Ing F	27. Menner of Deeth  1 Natural 5 □ Pending			Time of njury	28c. Inju			8d. Describe r	now injury occur	red				
S	tend leath lor: / the f	2 Accident investigati 3 Suicide 6 Could not	he		N		Yes 2□								
≦ '	tal or Attending P rs efter death. al Director: After t ied in by the funera  Certification:	4 ☐ Homicide determine	200. Flace U	Inju <b>ry</b> - At home, fa etc. ( <i>Specify)</i>	rm, street, t	actory, office		2	City or Tow	Street and Numi vn, State)	oer or Hurai	Houte Num	ber,		
_	urs ours ours	20. 0. 15													
	To the Hospital or Attending Physician: The law requires that the death within 24 hearts efter death.  To the Funeral Director: After this certificate has been signed by the etter completely filled in by the funeral director, page 2 should be detached for to Medical Certification: To Be Completed by Physician	(Check only 2 Medical Ex	hysician: To the be miner: On the basis	of examination end	, aeeth occu d/or investig	urred at the tir pation, in my d	me, date an opinion, deat	o place, ai th occurre	nd due to the o d at the time, o	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s	;)		
	thin 2 the outple	one) 29b. Signature and title of certifier	and manner	sidieu.		29c, Licens	se number			29d. Date signe	d (Month /	Nev Voerl			
	5 × 5 8	Sold and the or certifier					323	$\overline{}$		April			4		
1		1. We wo		9			1-3	/		14211	1 ( / 4		1		
(	3/	30. Neme end eddress of person who		f death (Item 23e) (	Type, Print)	10	K. n.	# 100	n /	rel m	070	200			
		1 1 1 1 1 1	rong M.		LUV	54/ F	1110	म 10	LLau	LEI 100	11 20	101			
	State Registrar	31. Date filed (Month, Day, Year)  APR 2 0 200		strer's Signeture	1	•									
15	11091511 01		K. M. Walland		TARK!										

DHMH 16 Rev 6/95

CENTER

7. Age (In vrs. last birthday)

1. Decedent's Name (First, Middle, Last)

2. Date of Death 04 - 08

JESSIE VAUGHAN 4a. Fecility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND

MEDICAL 4b. City, Town, or Location of Death 2004 4c. County of Death

**Funeral** Director

show

r than "naturel", or items 23s or 28s-f shov the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene important: if Item 27 is marked other than "in eny Injury or other traumatic event, Ita Med 2008.

Physician

Examiner

/Medical

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24 hours after deatle Funerel Director:

death certificate be executed

P.O. Box 68760,

of Vital Records,

**Division** 

Physician:

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Completed

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Examiner

Physician/Medical

Completed by

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Certification:

Medical

death

within 72 hours after

Maryland 21215-0036

Baltimore,

Usual Residence of Decedent Maryland Director 10e. Street and Number Funeral

1 □ M 89 10b. County 10c. City, Town or Location

BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min.

NIA 8. Date of Birth (Month, Day, Year) 13. 1914

USA

 Birthplace (State or Foreign Country) Michigan 10d. Inside City Limits

Kent Chestertown

10f. Zip Code 21620

1√2 Yes 2 No 10g. Citizen of What Country?

2029 Heron Point 500 Campus Ave. 11. Marital Status

5. Social Security Numbe

197-28-5228

1 Never Married 2 Married 3 57 Widowed 4 □ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian. Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12

17. Father's Name (First, Middle, Last)

Alumni Secretary

Education 18. Mother's Name (First, Middle, Maiden Sumame)

Closson Lockwood

19a. Informant's Name/Relationship (Type, Print) Andy Detterline/ daughter

Katherine Pantlind 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

2007 Saffron Way Collegeville, PA 19426

20a. Method of Disposition

Kuil 9

1 ☐ Burial 2 1 Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

\* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License

Chesapeake Cremation Cntr. 4/10 Stevensville, MD

22. Name and Address of Facility Fellows, Helfenbein, & Newnam Funeral Home PA 130 Speer Road Chestertown, MD 21620

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

resulting in death) Last

TYPE 2 ODONTOID FRACTURE Due to (or as a consequence of)

VERTEBRAL FRACTURE Due to (or as a consequence of)

COAGULOPATHY Due to (or as a consequence of):

CEREBROVASCULAR ACCIDEN

3 days

9 years

Approximate Interval Between Onset and Death

days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 9 Ulnknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

2 No

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY AKTERY DISEASE ATRIAL FIBRILLATION

RENAL INSUFFICIENCY

6 Could not be determined

24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 Probably 4 Unknown

25. Was case referred to medical examiner?
1 ✓ Yes 2 □ No

Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 5 Pending investigation 1 Natural
2 Accident

28b. Time of Injury 1835 04-05-2004 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 🗹 No

FROM WHEELCHAIR Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 ☐ Suicide

4 ☐ Homicide

HERON POINT NURSING HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

CHESTERTOWN, MD

29b. Signature and title of certifier

Anm Hon , MD

RES000

29c. License number

29d. Date signed (Month, Day, Year)

04-08-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANSEN 22 SOUTH GREENE STREET - BALTIMORE, MD NAHTANOL

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registre's Signature 1 4 2004



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April 20,2004 ALMA A. WRIGHT 0338 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months 1 M 2 XF 78 JULY 27 MO **Dírector** 364-28-143<u>6</u> Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28e-f show 1X Yes 2 No Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA #4 BAY STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Item any injury or other traumatic event, the Maulcal Exercipiest once. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION 12 TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THEODORE ROOSEVELT ARGO FRANKIE MAE ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 832 EASTON, MD 21601 GARY R. WRIGHT/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN MEMORIAL PARK 4-23-2004 4 Donation 5 Other (Specify) EASTON, MARYLAND 21. Signature of Funera/Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 M. E. Newhark 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONSCITTA **Physician** ACUIT 12 OVEL /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ding physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) page 2 should be detached 1 ☐ Yes 2 € No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 ☐ No I or Attending Physician: after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 ☑ No 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Sunn

30. Name and address of person

LUDWIG J. 31. Date filed (Month, Day,

EGLSEDER

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

III M.D. 503 IDLEWILD AVE EASTON, MD 21601

npleted cause of death (Item 23a) (Type Fint)

32. Registrar's Signature

			1 - For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of F	lealth and N Death		jiene 19g. No.	2004	14	733
Н	Physici		1. Decedent's Name (First, Middle, Last)  Dennis Kelliher Wa	0 Mm 0 W				2. Date of Dea Month April	th Day	Year 2004	3. Time of 0	
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of Death Annapoli		4c.	County of Death Anne Ar		
	uneral Director		301-20-2109	7. Age (In yrs. In 71	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April		Cour	lace (State or otry)	
death with the Maryland	fied at	tor	Usual Residence of Decedent		, Town or Lo					1	0d. Inside City	
n with the	3a or 28a	I Directo	10e. Street and Number 1301 Hawkins Lane			10f. Zip Code 21403	- day ê		-	ed State		
OUSO hours after deat	Department of Health and Mental Fyglene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show important: If item 27 is marked other than "naturel; or items 23a or 28a-f show important: If item 27 is marked ovent, Ina Medical Examinat man be notified at ance.	d by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ■ Yes 2 □ No If Yes, Give Year or Dates: 1954	H	Vas Decedent of Hi Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)			etc.	
16121 Within 72 h	sne. than "natu sa Madica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	OO NOT use retired	during most of work	ting		nd of Business/Ind	,	
Iand A	lental Hygie rkad other l lic event, II	To Be Co	17. Father's Name (First, Middle, Last)  Dennis Charles Ke.	4 lliher	aut	hor	18. Mother's Nam	e (First, Middle,	Maiden .	f employ Sumame)	red	
Mary nd 2 shou	27 is mai r treums		19a. Informant's Name/Relationship (Typ) Raymond D. Warner/			•	and Number or Rur Road Gree				Code)	
more, Pages 1 a	ent of Hei nt: If item ry or othe	) S	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, cren	sition (Name of natory or other place Cremato	ry 4-21-			imore M		
Dalitimor	Ueparim Importar any inju		21. Signature of Funeral Service Lipenser  21. Signature of Funeral Service Lipenser		22	. Name and Addre	ss of Facility Jo	hn M. Ta	ay 1o	r Funera	1 Home	
/[	hysician /Medical :xaminer	dical Examiner	23a. Pant 1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to (or as a consequence)	rence of):	HEN	ART F	ALLUG	2-6		Approximate Interval Between Onset and D	eath
death death	been signed by the attending ph should be detached for use as t	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 [	Ectopic pregnancy Other (specify)	,		2	3d. Date of delive Month	*	ear
ecords, F.O.	n signed by uld be deta	by P	Part II. Other significant conditions cont	ributing to death but not resu	itting in the ur	nderlying cause giv	en in Part I.	23e. Did to.	All	se contribute to th	e cause of de ably 4 □Ur	
The law	has Je 2	Completed						24a. Was a autops perform	sy	24b. Were auto prior to cor death? 1 \( \subseteq \text{Yes}		vailable use of
IVISION OF VITAL or Attending Physician: T	within 24 hours after death.  To the Funerel Director: After this certificate completely filled in by the funeral director, pag	ertification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	ospital: 1 Inpatient 2 I 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At ho building, etc. (Specify	28b. Time of Injury	28c. Injur Wor M 1	4   Indising no	ome 5 Reside 28d. Describe he	ence 6 ow injury	d Number or Rura		eer,
Hospitel o	within 24 hours after deal  To the Funeral Director: completely filled in by the	edical Ce		ician: To the best of my knower: On the basis of examinat and manner stated.								
To the	To the complete	Me	29b. Signature and title of certifier	sandsh,	mp	29c. Licens			!	signed (Month, i	Day, Year)	
			30. Name and address of person who cor	CAR PARK	WAY,	Print) L.	141417 K. Es. 520 A	5 ANDO	65	no pio	2140	1
9	Sta Registr		31. Date filed (Month, Day, Year)	32. Retistrar's Signat	ure	Charles				-		

			Amend Item/20b perstate 1- For Fun.Dir 4/26/04 1- Registrar AACo.Health Dept. B	e of Maryland / De	partment of Health ertificate of Death		iene 2004	14734
	Dhysisi		Decedent's Name (First, Middle, Last)			2. Date of Death Month	h Dav Year	3. Time of Death
	Physici /Medio		Albert F. Wright			April April	20 2004	8:00A M
	Examir	er	4a. Facility Name (If not institution, give street and 103 Rosewood St.		Annapolis		Anne Aru	ındel
	Funeral Director		5. Social Security Number 439-05-1986 6. Sex 1 ₹ M 2□	7. Age (In yrs. last birthda F 87 Yrs.	y) If Under 1 Year If Under Months Days Hours		9. Birth 1917 Loui	plece (State or Foreign ntry) .S1ana
	aryland show	7	Usuel Residence of Decedent  10a. State  10b. County	10c. City, Town or				10d. fnside City Limits 1 ☑ Yes 2 ☐ No
	the M	ectc	Maryland Anne Arunde	el Annapo	10f. Zip Code	10	Og. Citizen of What Cou	
	3a or	I D	103 Rosewood St.		21401		USA	
336	should be filed within 72 hours after death with the Maryland and Mentle Hygiene. Thygiene 14 hygiene 15 a cr 28a-f show marked other than "naturel", or litems 23a or 28a-f show matic event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married MXY	Decedent Ever in U.S. d Forces? les 2 \( \) No, Give or Dates \( \) 9 3 5 - 5 9	Was Decedent of Hispanic Or ff Yes, specify Cuban, Mexica     □ Yes 2  No Specify.		14. Race - Ameri Black, White, Specify: B1 a	, etc.
- - - - - - - - - - - - - - - - - - -	in 72 hou	Completed	15. Decedent's Education (Specify only highest grade complet	red) 16a. De (Gi	cedent's Usual Occupation ve kind of work done during mos . DO NOT use retired)	it of working	nited Sta	ndustry Ltes
212	d with giene.	omo	Elementary/Secondary (0-12) Coffee O	ge (1-4or 5+)	stodian	N	aval Acad	lemy
Maryland 21215-0036		To Be C	17. Father's Name (First, Middle, Last) Unobtainable			ers Name <i>(First, Middle, M</i> ie Whitake	,	
	18 is a 2		19a. Informant's Name/Relationship <i>(Type, Print)</i> Jonathan Wright(Son		Rosewood St.			· · · · · · · · · · · · · · · · · · ·
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr.		20a. Method of Disposition  1	rom State 20b. Place of Dis Bestera t Park	position (Name of the start of		nnapolis,	
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	100483	22. Name and Address of Facili Wm. Reese & 821 West St.	Sons Mortu	ary, P.A.	0.1
	nysician /Medical Examiner			to (or a a consequence of):				Approximate Interval Between Onset and Death
8/60,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence of):				
O. Box 6	the death certific y the attending pl sched for use as t	Physician/Me	in the past 12 months?		3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
ds, P	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in Part	. 23e. Did tob	acco use contribute to t s 2⊠No 3 ☐ Prot	
Records,	: The faw requires that the cate has been signed by th page 2 should be detache	Completed	Serile Demo	ite		24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
Vital	i <b>cian:</b> Th certificate rector, paç	Be C	25. Was case referred to medical examiner?			of Death (Check only one		
0	Physic this or	은	1 ☐ Yes \$ No Hospital:	□ Inpatient 2 □ EP/Outpat late of Injury 28b. Time		ursing Home 5 X Resider		(y)
o	ading F th. : After s funera	tion	Natural 5 Pending  Accident investigation	Month, Day Year) Injury			w injury occurred	
Division	ol or Attendia after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. P	face of Injury - At home, farm, uilding, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura State)	al Route Number,
	Hospite 4 hours Funere ely fille	edical C	(Check only 2 Medical Examiner: On the		ath occurred at the time, date ar investigation, in my opinion, dea			
	To the I within 2 To the Complet	Me	29b. Signature and title of certifier	July	Ac. License number	J3 129	d. Date signed (Month,	Day, Year)
			30. Name and address of person who completed of	cause of _ath (Item 23a) (Ty	Medical Plan	in Arak, vu	and one	401
100	Sta	te	31. Date filed (Month, Day, Year) APR 2 6 2004	2. P distrar's Signature	Ando			

			1 - For State of Maryland / Department of Certificate of	Health and Mental H	ygiene 2004 14735
	Physici /Medic		Decedent's Name (First, Middle, Last)     Mark WEISS	2. Date of D Month April	Death Day Year 3. Time of Death 19, 2004 5:25 P
	Examin			or Location of Death r Spring	4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 124-09-3397 6. Sex 1 Months Days	s Hours Min. (Month, E	9. Birthplace (State or Foreign Country) 9, 1910 Germany
	ryland thow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	the Ma 28a-f	Director	Maryland Montgomery Silver Sprin  10e. Street and Number 10f. Zip Code		1 Tyes 2 No 10g. Citizen of What Country?
	23a or		11107 Inwood Avenue	20902	United States
920	172 hours after death with the Maryland "naturel", or Items 23a or 28a-1 show galcal Examinations the notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Hispanic Origin? (Specify Yes or N ban, Mexican, Puerto Rican, etc.) o Specify:	14. Race - American Indian, Black, White, etc.  Specify: white
15-0	n 72 ho "natur edical	leted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work don-	upation e during most of working ed)	16b. Kind of Business/Industry
212	be filed within stat Hygiene. Ind other then "event, I've Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Self-Employe	-	Camera Stores
Maryland 21215-0036	should be and Mental s marked o sumatic eve	To Be	17. Father's Name (First, Middle, Last)  Meyer Weiss	18. Mother's Name (First, Middle Leah Brenne:	
Mary		-			ber, City or Town, State, Zip Code)
di.	and lealt m 2		Helen Golan, Daughter  4 Clemson Cou  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other pl	rrt, Rockville,	MD 20850 20c. Location - City or Town, State
Baltimore,	Page Ment o Jury or		'4 □Donation 5 □ Other (Specify) Mt. Lebanon Cemet	ery 04/21/04	Adelphi, MD
Ball	permit. Pages 1 Department of H Importent: If ite any injury or ot			y Hebrew Funeral	
	arrest, DC 20012 Approximate Interval Between Onset and Death				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   TSellaric - Conquistre  Due to (or as a consequence of):	Disease	parky
	Examiner		Sequentially list conditions, b. Coronary Artary	DISEASE	
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  Lugary (or as a consequence of):  Lugary (or as a consequence of):  Lugary (or as a consequence of):		
8760,	icate be executed physician and the burial-transit		resulting in death) Last Due to ( <b>Pras</b> a consequence of):		
9	ntificate ng phys s as the	Medic	IF FEMALE:		
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and otge 2 should be detached for use as the burial-transit	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	гу	23d. Date of delivery Month Day Year
ords, P	w requires that been signed b should be deta	by	Part I Other significant conditions contributing to death but not resulting in the underlying cause g		tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4
Vital Records,		Completed		peri 1 ☐ Yes	prior to completion of cause of death?  2 1 Yes 2 No
of Vit	nysic lis ce dirac	То Ве	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Department 2 ER/Outpatient 3 DOA O	26. Place of Death (Check only ther: 4 ☐ Nursing Home 5 ☐ Res	
	ing After unel		27. Manner of Death 1 □Mettral 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Will My 11	ury at 28d. Describe ork? □ Yes 2 □ No	how injury occurred
Division	tal or Attending s after death. el Director: After ed in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location	(Street and Number or Rural Route Number, own, State)
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical (	29a. Certifier (Check only one)  1 Greek only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	time, date and place, and due to the opinion, death occurred at the time	e cause(s) and manner as stated. , date and place, and due to the cause(s)
<b>.</b>	4	Me	29b. Signature and title of certified 29c. Licer	nse number	29d. Daje signed (Month, Day, Year) 4 (20 / 64
7	12	_	39. Name and address of person who completed cause of death (Item 23a) (Type, Print)	3027	110-107
	Sta	ote.	Gary E. Raffel 5411 W. Cedar Lane, #202 31. Date filed (Month, Day, Year) 32. Registrar's Signature		20814
	Registi	- 1	APR 2 2 2004  31. Date filed (Month, Day, Year)  APR 2 2 2004	/	

			For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of H rtificate of L	lealth and M Death	lental Hygi	ene 2001	14736
,	Dhuoini	310	1. Decedent's Name (First, Middle, La	est)				<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	Physicia /Medic	_	Rufus D.	Wells, Jr.				April	18 2004	1:15 P M
	Examin	er	4a. Facility Name (If not institution, gi		L 1	,	Location of Death		4c. County of Deat	
	349 /w		Shady Grove Ac 5. Social Security Number 6.		rs. last birthday)	Rockvil  If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgome 9. Birt	
	Funeral Director		230-07-2991	1 X M 2 □ F 8		Months Days	Hours Min.	June 6,	1922 Vir	hplace (State or Foreign untry) ginia
	aryland show	_	Usual Residence of Decedent  10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8e-f	Directo	Maryland Montgor	nery R	ockvill	e 10f. Zip Code		1/	Og. Citizen of What Co	
	with t		10e. Street and Number	\d		20854			United Sta	
	eath	erai	1399 Stratton I	12. Was Decedent Ever in	U.S. 13. 1	Was Decedent of H			14. Race - Ame	nican Indian,
326	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28e-1 show aumatic event, the Medical Examinational De notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		If Yes, specify Cuba 1 ☐ Yes 2 🎛 No	sn, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	e, etc. ack
Š	72 hou	ted	15. Decedent's I		16a. Decedent's Usual Occupation (Give kind of work done during most of workin)				16b. Kind of Business	Industry
21215-0036	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		N	_
	filed within Hygiene. other than	S	17. Father's Name (First, Middle, Las	3	Journ	nalist	18. Mother's Name	e (First, Middle, N	Newspaper	
Maryland	ould be f Mental It warked of	Be c	Rufus D. Wells	,			Lara P			
2	should nd Me mark matic	၉	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street			City or Town, State, a	Zip Code)
Σ	lith ar 27 is r trau		Hattie Wells /		1399	Stratton	Drive R	ockville	, Maryland	1 20854
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5 Other (Spec	20t □Removal from State		osition (Name of matory or other place itan Crem	ADL	11 20.	20c. Location - City or	
Baltin	Departme Importan sny injury		21. Signature of Sineral Service Lice		22	2. Name and Addres	ss of Facility DeV	ol Funer	al Home	
f	*2		23a. Part1. Entey the disease, or co shock, or beart failure. List onl	ersburg, MI est.	Approximate Interval Between Onset and Death					
	Physician /Medical Examiner		disease or condition resulting in death)	Pulmonary  Due to (or as a cons		a				4 Months
2/10 2/10 7/10	n & .	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Dies to (or as a cons	sequanda of):					
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) cast	Due to (or as a cons	sequence oi):					
	tificat ng phy as th									
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of del Month	livery Day Year
	quires that I n signed by uld be deta	by	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause giv	en in Part I.		pacco use contribute to es 2 □ No 3 □ Pi	o the cause of death?
Division of Vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of 2 No
/ita	Physician: r this certifica ral director, i	Be (	25. Was case referred to medical examiner?					h (Check only on	θ)	
2	hysic	မ	1 ☐ Yes 2 😾 No	Hospital: 1 Inpatient 2			4   Nuising no		ence 6 Other (Spe	cify)
ion	Attending P r death. ector; After t by the funera	ation:	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigat		28b. Time o Injury	Wor	y at k? Yes 2 □No	28d. Describe ho	ow injury occurred	
Divis	al or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			reet, factory, office		28f. Location (Sti City or Town	reet and Number or Ri n, State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After the completely filled in by the funeral	edical C	29a. Certifier 1X Certifying I (Check only one) 2 Madical Ex	Physician: To the best of my aminer: On the basis of examand manner stated.	knowledge, deat nination and/or in	th occurred at the tin	me, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
\ \	/ .	Me	29b. Signature and title of certifier	1. Haggerty	mD	29c. Licens			9d. Date signed (Mont	•
•	5+1		30. Name and address of person wh	o completed cause of death (	Item 23a) (Type,	, Print)	32407		April 20,	
	Sta	ate	Joseph M. Hags	gerty, M.D. 9		ical Cent		SUU Rocl	kville, MD	20830
1	Regist		APR 212		19	Sparks	/			

		•	For State Registrar	State of Ma	iryland / De	epartment of F Certificate of	lealth and N <i>Death</i>		iene 200	4 14737
ı	Physicia	an	1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat Month	h Day Ye <i>a</i> r	3. Time of Death
	/Medic			Whitty		1 4 65 7	1	April 1		8:25P M
	Examin	er	4a. Facility Name (If not institution, given National Luthers			Rockvil	r Location of Death		4c. County of Dea	
Ŧ	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign Country)
	Director		577-09-2391	□M 2 <b>전</b> F	95 Yr	s. Months Days	Hours Min.	Novembe	r1,1908 Wa	ash.,D.C.
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryla f sho	٥	D.C. none		Washin	gton				1 ☑ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number	·		10f. Zip Code		1	Og. Citizen of What C	Country?
	death with the Maryland ms 23a or 28a-f show rinust be notified at	al D	5112 38th Street	, N.W.		2001	6		U.S.A.	
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Brain injury or other traumatic avant, the Medical Examinating the notified at once.	by Funeral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X N If Yes, Give		13. Was Decedent of H If Yes, specify Cuba 1  Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	ite, etc.
3-003c	hour tural'		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a. D	Decedent's Usual Occup	pation		16b. Kind of Busines	hite s/Industry
<u>.</u>	nin 72 In "na Wedio	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5-		Decedent's Usual Occup Give kind of work done ife. DO NOT use retired		king		,
7	ad with	Completed	Elementary/Secondary (0-12)	4	Exe	ecutive Sec	retary		ITT/Imper	ial
and	tal Hy de file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam Catherin			
<u> </u>	d Men nerka narka	P	Richard P. Whitty 19a. Informant's Name/Relationship (		10h A	Mailing Address (Street				Zin Code)
Z Z	id 2 st ith and 27 is r traur		John William Whitt			17 Ogden Ro			•	
ē,	Heal Heal Ham		20a. Method of Disposition			Disposition (Name of crematory or other place	1	Date	20c. Location - City o	
Ê	Page nent o		1 ⊠ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify			Hill Cemete	ADTI	1 19, 004	Suitland,	Maryland
Baitimore,	permit. Departri Importa any inju		21. Signature of meral Service for	eral Home .D.C. 2000	)7					
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do no					Approximate Interval Between
	Physician	į.	Immediate Cause (Final disease or condition	. End	Sta	Re Alah	eemer			Ons and Death
	/Medical Examiner		resulting in death)	Due to for as a	consequence	/			THE PARTY OF THE P	110 Anue
		Į.	Sequentially list conditions,	b. Due to (or 1 a	consequence of	):				( ceargy
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	an and rial-tra		resulting in death) Last	Due to (or as a	consequence of	):				
09/89	ificate be executed physician and as the burial-transit	edical	(	d						
5			IF FEMALE:	23c. If yes, outcome	of pregnancy				001 5 11 11	
С. Бох	w requires that the death certif been signed by the attending should be detached for use a	hysiclan/M	23b. Was decedent pregnant in the past 12 months2 1 ☐ Yes 2 ☐ M6 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	<i>'</i>		23d. Date of de Month	Day Year
rds, P	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions of	2/	nt not resulting in a	,	en in Part I. Clest			to the cause of death?  Probably 4 Unknown
Vital Record	e la has le 2	Completed						24a. Was ar autops perform 1 🗆 Yes 2	ned? death?	utopsy findings available completion of cause of s
IIa	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Hamital.		On.		th (Check only on	9)	
0	S S =	10 10	1 Yes 2 No	Hospital: 1  Inpatie	The state of the s		4 Hursing Ho		nce 6 Other (Spewinjury occurred	ecify)
$\subseteq$	ing lifter Ine	tion	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		ury Wor	k? Yes 2 □No	Edd. Bosonbo no	w injury cocurred	
DIVISION	ie Hospital or Attanding n 24 hours after death. na Funaral Director: After kletely filled in by the funer	ertification;	3 Suicide 6 Could not b	e Osa Blaco of Inju	ry - At home, farn . (Specify)	n, street, factory, office		28f. Location (Sti City or Town	eet and Number or F , State)	Rural Route Number,
	e Hospital or Al 1.24 hours after or 1a Funaral Directetely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysicien: To the best on miner: On the basis of and manner sta	examination and/	death occurred at the tir or investigation, in my o	ne, date and place, ppinion, death occur	and due to the ca	use(s) and manner a ite and place, and du	es stated. e to the cause(s)
1	To the twithin 2. To that complet	Me	29b. Signature and title of certifier	W. Ker	resh v	29c. Licens	1726	2	Od. Date signed (Mon	ith, Day, Year) 1, 200 4
	Ψ		30. Name and address of person who	completed cause of de	eath (Item 23a) (T		jeRd. Da	mascas	Md. 20	72
	Sta Registr		31. Date filed (North Pay Year) 20	32. Registra	r's Signature	Spark				

			Please	Type or Print				•	•	e.	
			1 - For State Registrar	State of Man	-	rtificate of D			g. No.	4 14738	
	Dhysisi		1. Decedent's Name (First, Middle, Las					2. Date of Death Month		3. Time of Death	
	Physici /Medic		Emeile Isbel Wi	nfield, Jr.		·		APRIL	17, 200	of 10:28 AM	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		h	4c. County of		
			Doctors Communit  5. Social Security Number 6. S		n yrs. last birthday)	Lanhar	II If Under 24 Hrs	8. Date of Birth	9	Georges  Birthplace (State or Foreign	
п	Funeral Director			IXM 2□F	76 Yrs.	Months Days	Hours Min.		1927	Country) Illinois	
	D		Usual Residence of Decedent			<u></u>					
	anylar show	_	10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 No	
	Ba-f	ecto	Maryland   Prince (	Georges	Springda				0.0000000000000000000000000000000000000		
	with t	Dir	10e. Street and Number 3512 Jeff Road			10f. Zip Code 20774			Og. Citizen of What Country? United States		
	leath	eral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S		14. Race - American Indian,		
ധ	after or iter	Fun	1 ☐ Never Married 2 💢 Married	Armed Forces? 1 XYes 2 ☐ No	エクサンー	If Yes, specify Cubar  1 ☐ Yes 2 X No		o Rican, etc.)		White, etc.	
Ö	ral', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1948	TEL Yes ZIAINO	Specify:		Specify: Afri	can American	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Itema 23a or 28a-f show ant, the Modred Excollect rush by moffled at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wo	rking	6b. Kind of Busin	ness/Industry	
2	withir ene. than	Jmp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		pervisor (		Arts &	U.S. Go	vernment	
	10a. State   10b. County   10c. City, Town or Location   10c. City, Town or Location   10c. Street and Number   10d. Zip Code   10d. Zip Code   20774   United   20d. Married   11d. Martial Status   1										
<u>la</u>	Ald be Aenta rked tic ev	Emeile Isbel Winfield, Sr. Lillie Gray									
Maryland	shou	5	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street a	nd Number or Ru	ıral Route Number,	City or Town, Sta	ate, Zip Code)	
	and and mostly mm 27 mm 27 her tri		Arleen Dent Winfi		1000	Jeff Road	and the second second				
ore	T ite		20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐	Removal from State		osition (Name of matory or other place			0c. Location - Cit	ty or Town, State	
Baltimore,	tant:		' 4 □ Donation 5 □ Other (Specif	y)		ke Cremato				le, Maryland	
Bal	Departing Department of the popular		21. Signature of Funeral Service Licer	1500		2. Name and Address					
	- 10		23a. Part1. Enter the disease, or com	plications that caused the		400 Georgi ter the mode of dying				Approximate	
	Physician ·	3 3	shock, or heart failure. List only Immediate Cause (Final disease or condition		w Contitl					Interval Between Onset and Death	
	/Medical		resulting in death)  Due to (or as a tonsequence of):								
	Examiner		Sequentially list conditions, b. A aut Rinal Failure							+	
	pe tis	aminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):						
_	xecuted and Il-transit		that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):		<del></del>				
68760,	death certificate be ex e attending physician ( id for use as the burial	aiE	l l	,	, ,						
687	ificate g phys	edic		. 0.							
Вох	h cert	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy			23d. Date o		
	O 0 0	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant at tim		Other (specify)			Month	Day Year	
P.0	law requires that the de as been signed by the a 2 should be detached t	Physician/Medical	9 Unknown		not roculting in the	and a decision and a succession of the	a in Doubl	220 Did tob	ann una contribu	ite to the cause of death?	
ŝ	ires († signe d be d	by	Part II. Other significant conditions of	ontributing to death but r	iot resulting in the u	indenying cause give	n in Part I.			Probably 4 Monknown	
ecords,	w raquire baan si should b	Completed									
Rec	The law ate has l	mpi						24a. Was an autopsy perform	ed? prio	re autopsy findings available in to completion of cause of th?	
		e Co	25. Was case referred to medical				OC Place of Day	1 ☐ Yes 2		Yes 2 No	
Vital	Physician: this certific ral director,	0 0	examiner?	Hospital:	2 ER/Outpatier	nt 3 DOA Othe		lome 5 ☐ Resider		(Specify)	
1 of		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time o		at	28d. Describe how			
Sio	Attending r death. ector: After oy the fune	atic	2 Accident investigatio	n	, , , , ,		′es 2□No				
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (		reet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,	
	Hospital or Attan 24 hours after deat Funeral Director: stely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of n	ny knowledge dest	h occurred at the time	e date and place	and due to the co	isa(s) and man	or as stated	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical		niner: On the best of n niner: On the basis of ex and manner stated	amination and/or in						
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier			29c. License		29	4	Month, Day, Year)	
}	14+1		> Routon F	arahi L	MD	De	13446	1.0	4/10	1/04	
	11 1										

State Registrar

FARAH, FAR M.D. 98616wagig Ave suit 3-41 S. Ivagring Mo 20902

Year) 2004 32. Registrar's Signature & Sparks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUINTAN

31. Date filed (Month Pay, Year) 1 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#10a-c, e, fperINF4/19/04, EM, MC Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 13<sup>y</sup> 2004 LORRAINE EVELYN WASHBURN April 5:30P M 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) March 6, 1929 9. Birthplace (State or Fo Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1 ☐ M 2 🗓 F Yrs. 75 009-18-6383 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Bradenton FIorida 10b. County Mantee 1⊠Yes 2 No Maryland 19e Street and Number 1228 58th Street-West 1221 Howard Road 10g. Citizen of What Country? U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 ⊠ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gene LeBlanc Proper Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy M. Vagnoni/Daughter 3100 Catrina Lane, Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Loundon Park Crematory 04/19/04 Baltimore, Maryland \*4 □ Donation 5 □ Other (Specify) 21, Signature of Funeral Service Licenses 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, 20904 INC. 20904 Silver Spring, MD 11800 New Hampshire Avenue, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) avcino ma one moint Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2240 Inpatient 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🔲 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier

Examine attending physician and for use as the burial-transit Box 68760 Physician/Medical the as o the Records, P. þ Completed has 13/04 ivision of Vital or Attending Physician: Be this Certification: After death. Director: within 24 hours after To the Funeral Dire

A SH BURN, LOPBRAINE

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

show

r than "natural", or Items 23a or 28a-f show If we Medical Examiner must be notified at

e filed within 72 hours after death vil Hyglene. Other than "natural", or Items 238

Pages 1 and 2 shoutd be fill ment of Health and Mental Hiant: If item 27 Is marked of

continent of Health are contained to the source of the sou

permit.
Departr
Imports
any nji

**Physician** 

/Medical Examiner

50

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

D State Registrar

31. Date filed (Month, Day, Year) APR 15

(Check only one)

29b. Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 751231 29d. Date signed (Month, Day, Year) ,2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gabriel Peter Pushkas, M.D., 11510 Old Georgetown Rd, Rockville, MD 20852

32. Pegistrar's Signature

ment

		1 - State Registra AMEND ITEM #1 P. 1. Decedent's Name (First, Middle, Last)		U//U4 Juge	uncate of	lealth and Death		Reg. No.	3. Time of Death
Physi /Med Exam	lical	4a. Facility Name (If not institution, give so the STER River	HOSP, TAI	Center	4b. City, Town, o	est-ert	Month 33	4c. County of De	1 2155 %
Funera Directo		5. Social Security Number 222–14–6531 6. Sep		yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hi		9. B 927 Del	rthplace (State or Foreign country) AWATE
the Maryland 28a-f ehow	rector	10a. State 10b. County Maryland Kent  10b. Street and Number		. City, Town or Lo				10g. Citizen of What C	10d. Inside City Limits 1 Yes 2 No
Dallillore, Ivial ylating A.I. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygjene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Eventinar must be notified at	Completed by Funeral Director	30840 River Road  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1		21651	Ispanic Origin?	(Specify Yes or No orto Rican, etc.)	USA	erican Indian, ite, etc.
MICE YICE TO SOLVE OF THE LOSS OF THE ACT OF	mpleted by	3 Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grade  Elementary/Secondary (0-12)	Year or Dates:	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	rorking	16b. Kind of Busines	
should be filed and Mental Hygis marked other umatic event, III	To Be Co	12 17. Father's Name (First, Middle, Last) Henry Ashe 19a. Informant's Name/Relationship (Ty	ge Print)			Hattie '	Townsend	Factory Maiden Sumame) or, City or Town, State,	Zin Code)
Pages 1 and 2 sl nent of Health an int: If item 27 Is r ary or other traur		Jeanine Wilson / Da  20a. Method of Disposition  1 ♥ Burial 2 □ Cremation 3 □ R	aughter	30840 b. Place of Disponentery, cree	River Ro	oad, Mil	lington,	Maryland 2 20c. Location - City o	1651 r Town, State
Deficiency Pages 1 at Department of Heal Important: If item any injury or othe	i dire	21. Signature of Funeral Service License		Fe.	.M. Cemet Name and Addre Llows, He D. W. Cypr	ss of Facility elfenbei	/06/2004 n & Newna eet. Mill	Chesterv m Funeral ington, MC	Home, P.A.
Physicial /Medica Examine		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	cations that caused the cause on each line.  Due to (or as a con	Can		ng, such as cardi	ac or réspiratory ar	rest, T	Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	dlcal Examiner	if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con						
death certif e attending d for use a	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	elivery Day Year
9 S S	ğ	Part II. Other significant conditions con	itributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
	Completed	Precmoni	ζ					sy prior to death?	utopsy findings available completion of cause of s 2 \(\sime\) No
ding Phy h. After this funeral d	atlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient  28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time or Injury	28c. Injur Wor	er: 4 🗆 Nursing		ne) ience 6 Other (Spa	acify)
in Qife	I Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Abuilding, etc. (Sp	pecify)		no data and ri-	City or Tow		
To the Hospital within 24 hours a To the Funeral I completely filled	Medical		aician: To the best of my ner: On the basis of exar and manner stated.			pinion, death occ	curred at the time,		e to the cause(s)
		PAU A Donc	sher al	190	Main			MD 216	35
S Regis	tate trar	31. Date filed (Month.	32. Register's S	ignature	post				

							Month	Day	Vace	3. Time of Death
	ELAINE WI	LSON	_				04		Year 004	3:30p <sup>M</sup>
4	a. Facility Name (If not instituti	on, give street and n	umber)		4b. City, Town, o	or Location of Death		4c. County		
	34058 Clearfie		7 4=0 //=	local high day	Pocomok If Under 1 Year		0. Date of Righ	Some:		(0)
	i. Social Security Number 088–50–2716	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	. iasi birtiday, 48	Months Days	Hours Min.	8. Date of Birth (Month, Day, 12/16/1	Year)	Countr	ce (State or Foreign y) CONSIN
ī	Jsual Residence of Decedent						12/10/1	555		
	Oa. State 10b. Coun	ty							100	d. Inside City Limits 1 ☐ Yes 2 ☐ No
		set	Po	comoke			10	022		
5		ld Dwirro					10			y r
5		12. Was De		J.S. 13.		Hispanic Origin? (Sp	ecify Yes or No-	14. Race	e - Americar	
3	1 Never Married 2 Ma	arried 1 Yes	2 🔼 No				Hican, etc.)			
2		ed Year or	Dates:						WI	nite
	(Specify only high	est grade completed	)	(Give	kind of work done	during most of work	ing 16	6b. Kind of Bu	siness/Indu	stry
	Elementary/Secondary (0-12)	Coilege	(1-4or 5+)			-7	R	etail		
2	17. Father's Name (First, Middle	e, Last)				18. Mother's Name	e (First, Middle, Ma	aiden Sumam	e)	
2	Charles Hulsi	zer				Mary Ly	nn James			
				14.	-			-		
		ickerell (	daughte	r) 184	U Cedar I	Hall Rd.,				
ľ	1 ☐ Burial 2 ☑ Cremation						_			
-			Sa							
	m.h. O	Do		1	Holloway	Melson Fu	neral Ho	me, P.	A. MD 218	851
+	23a. Part1. Enter the disease,	or complications that	caused the dea						A	Approximate nterval Between
1	Immediate Cause (Final			TIC	CARC	INOMA	OF B	REAS	T	Donset and Death
	resulting in death)	a								16/1/-5
	Sequentially list conditions,	b								
	THE PROPERTY OF THE PROPERTY O	- Cuero	(or as a consec	quenae orij:						
3	that initiated events	c. Due to	o (or as a consec	quence of):					_	
3		d								
	15 55 14 1 5	_								
3	23b. Was decedent pregnant				⊒Ectopic pregnanc	y		1		
2	1 ☐ Yes 2 ☑ No			death 5[	Other (specify)			No	iiii D	ay rear
=		tions contributing to	death but not res	sulting in the u	ınderiving çause giv	ven in Part I.	23e. Did toba	cco use contr	ibute to the	cause of death?
2		_		_			1 ☐ Yes	2 🗆 No	3 Probab	oly 4 Unknown
-							24a. Was an	24b. V	Vere autops	v findings available
-							autopsy performe	pd2 d	rior to comp eath?	oletion of cause of
3		al				26. Place of Death			i res 2	□ No
2	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient	P/Outpatie	at 3□ DOA Ott	ner			or (Specify)	
5	_/	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o	of 28c. Inju Wo	ry at rk?	28d. Describe how	injury occurre	∍d	
	2 Accident inves	stigation				-	-0/ / -1 -1			
	4 Homicide dete	mined 200. Flat	e of Injury - At h ding, etc. (Speci	nome, farm, st ify)	reet, factory, office				er or Rural F	Route Number,
5	29a. Certifier 1 Certify	ring Physician: To th	ne best of my kn	owledge, deal	h occurred at the ti	me, date and place.	and due to the cau	se(s) and mai	nner as state	ed
3	(Check only 2 Medic	el Examiner: On the	basis of examina	ation and/or in	vestigation, in my	opinion, death occurr	ed at the time, date	e and place, a	nd due to th	ne cause(s)
	29b. Signature and title of certif	ier /	10.	. 142	29c. Licens	se number	290	I. Date signed	(Month, Da	y, Year)
		1.00	Lev	n, m	1	4676	4	IPRIL	22	, 2004
				-	Print) M	CTD C	ET.	MD	21	853.
			,		C 2 1	2,10				
		MD Somer  10e. Street and Number  34058 Clearfie  11. Marital Status  1 Never Married 2 Marital Status  1 Never Married 2 Marital Status  1 Sequentially Secondary (0-12)  12. The State of Burning Secondary (0-12)  12. The State of Secondary (0-12)  12. The State of Secondary (0-12)  12. The State of Secondary (0-12)  13e. Informant's Name (First, Middle Charles Hulsing Secondary (0-12)  19a. Informant's Name/Relation  1 Burial 2 Commander  1 Burial 2 Commander  1 Burial 2 Commander  21. Signature of Funeral Service  23a. Part 1. Enter the disease, shock, or heart failure. Lift Immediate Cause (Final disease or condition resulting in death)  23a. Part 1. Enter the disease, shock, or heart failure. Lift Immediate Cause (Final disease or condition resulting in death)  23a. Part 1. Enter the disease, shock, or heart failure. Lift Immediate Cause (Final disease or condition resulting in death)  25a. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Dther significant conditions of the Secondary of Condition (Check only 9 Unknown)  25b. Was case referred to media examiner?  1 Yes 2 No 9 Unknown  27b. Manner of Death 1 Natural 5 Pener of Death 1	MD Somerset  10e. Street and Number  34058 Clearfield Drive  11. Marital Status  1	MD Somerset Po  10e. Street and Number  34058 Clearfield Drive  11. Martal Status  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Charles Hulsizer  19a. Informant's Name/Relationship (Type, Print)  Jennifer W. Pickerell (daughte 20a. Method of Disposition  1 □ Brail 2 ☒ Cremation 3 □ Removal from State  1 □ Dennifer W. Pickerell (daughte 20b. Signature of Funeful Service Licensee  21. Signature of Funeful Service Licensee  22. Signature of Funeful Service Licensee  23. Part I. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in dealth)  23. Part I. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in dealth)  24. □ Due to (or as a consection of the past 12 months?  1 □ Yes 2 □ No  25. Was case referred to medical examiner?  26. □ Due to (or as a consection of the past 12 months?  1 □ Yes 2 □ No  27. Manner of Death  28. Date of Injury (Month, Day Year)  29. Certifier (Check only a medical examiner: On the basis of examiner)  29. Signature and title of certifier  30. Name and address of person who completed cause of death (Ite M) S HI RAU M D S 2 Persistrar's Signature and title of certifier  31. Date filed (Month, Day, Year)  32. Date filed (Month, Day, Year)  33. Date filed (Month, Day, Year)  34. □ Date filed (Month, Day, Year)  35. Date filed (Month, Day, Year)	MD   Somerset   Pocomoke	MD   Somerset   Pocomoke City	MD   Somerset   Pocomoke City	Miles   Some and Number   10.5 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   13.0 pc Codes   10.3   13.0 pc Codes   10.3   13.0 pc Codes   13.0 pc C	MD   Somerset   Poccomoke City   10s, Sere and Number   10g, Citizen of Visited and Number   12g, Series and Number   12g, Series and Number   12g, Series and Number   12g, Series and Number   12g, Series and Number   12g, Series and Number   12g, Series and Number   12g, Series and Number   12g, Series and Number   12g, Series and Number   12g, Series and Number   12g, Series   12g, Serie	MD   Somerset

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death APRIL WARREN 2:04 PM RALPH 2004 4a Facility Name (III not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY If Under 24 Hrs. 6. Say 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number Birthplece (State or Foreign Country) Days 1 X M 2 □ F 78 222-14-0675 21/1925 DELAWARE Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1t Yes 2 No DELAWARE SUSSEX MILLSBORO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 322 W. STATE STREET 19966 12. Was Decedent Ever in U,S. Armed Forces? 1¼ Yes 2□No 46-66 If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) MEDICAL FIELD X-RAY TECHNICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILFORD BROWN WARREN CLARA PENUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN E. WARREN / WIFE 322 W. STATE ST., MILLSBORG, 19966 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MILLSBORO CEMETERY 4/22/04 MILLSBORO, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WATSON FUNERAL HOME, MILLSBORO, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYELD BENOUS LEVKEMIA MONTH Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? the Yes 200 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Alinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

been signed by the attending physician end should be detached for use es the bunel-transit

certificate has b

: After this of funerel dii

filled in by

To the Hospital
within 24 hours a
To the Funeral C
completely filled

director,

Physician/Medical Examiner

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Completed

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Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

2

Completed

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**Funeral** 

Director

permit. Peges 1 and 2 should be filled within 72 hours eftar deeth with the Marylend Depertment of Heelth end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, ms Madical Examinar must be notified at angles.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part

II.	Other significant	conditions	contributing to	death but no	ot resulting in	the underlying	cause given in	Part

	examiner?		
27	. Manner of	Death	

Date of Injury (Month, Dey Year) 5 Pending investigation

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c Injury at 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE, MO

202	Certifier
234.	Certillel
	(Check only

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier, MD

6 Could not be determined

RES - 000

STREET

29d. Date signed (Month, Day, Year) 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENNIM BARRY, MD

State Registrar

DHMH 16 Rev 6/95

Hospital or Attending Physician: The law requiras that tha death certificete ba exacuted

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Oay, Year) APR 2 1 2004

32. Registrar's Signature

600 NORTH WOLFE

**ORIGINAL** 

			1 - For State Registrar	State of M	aryland / [		artment tificate				Re	g. No.	04	14743
	Physici	an	Decedent's Name (First, Middle, Las								Date of Death Month	Day	Year	3. Time of Death
	/Medic	al .	Leah Catherine 4a. Facility Name (If not institution, give				4h City T	own or l	ocation of	Death	04	4c. County	of Death	2015 "
	Examin	er		medical d	108/11	-	40. O.y, 1	SAU	4560	n			mico	
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last bii	rthday)	If Under 1	Year Days	If Under 2	Hrs. 8.	Date of Birth (Month, Day,			lace (State or Foreign
ı.	Director		456-40-4720	□M 2 <b>∑</b> F	72	Yrs.	MOTILIS	Days	Tiodis		arch 30,			sylvania
	and .	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation						1	0d. Inside City Limits
	Manytt	ō	Maryland Wicomic	_	Salis	hur	3.7							1 ☐ Yes 2 🔀 No
	1 the 1	Director	10e. Street and Number	<u> </u>	Darie	Dar	10f. Zip 0	Code			10	g. Citizen of V	What Cour	ntry?
	h with	al D	27284 Independence	e Lane			218	801				τ	JSA	
	ems s	Funeral	11, Marital Status	12. Was Decedent Armed Forces?		13.	Was Decede	ent of His	panic Orig Mexican	in? (Specify Puerto Rice	y Yes or No- an, etc.)		e - Americ	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 😿 If Yes, Give			1 ☐ Yes 2		Specify:		,	Specify		ite
21215-0036	within 72 hours atter death with the Maryland ene. then "neturel", or Items 23e or 28e-f show t.e. Medical Examinet must be netified at	ed b	15. Decedent's Ed	Year or Dates:	16a	Dece	ient's Usual	Occupat	ion		1	6b. Kind of Bu		
15	n "ne	Completed	(Specify only highest gra-			(Give	kind of work OO NOT use	done du		of working				,
212	d with giene	mo	12	College (1-401.		sta	l Worl	ker				Federal	Gov	ernment
	al Hy d other	Be (	17. Father's Name (First, Middle, Last)						18. Mother	's Name (F	irst, Middle, M	laiden Sumam	7e)	
yla	i 2 should be filed within h and Mental Hygiene. 7 is marked other then ' Ireumatic event, It.e Me	2	Stephen	Mercer					Emil	_		Wilsor		
Maryland	12 sh h and 7 is n treum		19a. Informant's Name/Relationship (7		. 1						<sup>oute Number,</sup> Salisbi	-		
	1 and Healt Iem 2	1	Renee Stephens  20a. Method of Disposition	(daughte	20b. Place o	f Dispo	sition (Name	e of	1	Date	_	Oc. Location -		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, it is Medical Examiner must be notified at once.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		-	natory`or oth		1	Avoreil '	21 200	Calick	SHIPSE	Maryland
alti.	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licen		WICOILL	22	. Name and	Address	of Facility	,				
ä	Depared Important Importan		1 Ket R L	every CK	500	H	ollowa Ol Sna	ay F ow H	unera ill R	l Hom Road	e Profe Salisb	essiona urv, Ma	al As arvla	sociation nd 21804
	#		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each li	d the death. Do	not ent	er the mode	of dying,	such as c	ardiac or re	spiratory arre	st,	4	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. (-	1sam	tio	~	6 p-	وساسه	nia				3 clay
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):								
н	o)	-	Sequentially list conditions,	b. Due to (or as	a consequence	of):	nco						-	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	lune	Co	wes	-					4	
Ć,	exectin and ial-tra	Еха	resulting in death) Last	Due to (or as	a consequence	of):								
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		d										
9	artifica ing ph a as th	Med	IF FEMALE:											
Вох	death certifica attending ph d for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pre					23d. Dat	te of delive nth	ry Day Year
0.	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 L	] Other <i>(spe</i>	crty)						
<u>α</u>	res that the digned by the be detached		Part II. Other significant conditions of	ontributing to death b	out not resulting i	n the u	nderlying ca	use giver	n in Part I.		23e. Did toba	acco use contr	ribute to th	e cause of death?
Records,	n sign	d by									1 🗆 Yes	s 2 No	3 Prob	ably 4 Unknown
000	aw requir s been si 2 should	Completed									24a. Was an	24b. \	Were autor	psy findings available
R	The lav ate has page 2	шо									autopsy perform	ed?	death?	npletion of cause of 2□ No
Vital		Be C	25. Was case referred to medical examiner?						26. Place	of Death (C	heck only one			
of V	Physician: this certitics ral director, p	2	1 ☐ Yes 2 ☐ No	Hospital: Inpati					4 🔲 Nurs		5 Resider			1)
n c	ding Physician: n. Atter this certitic funeral director,	lon:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	lry Year) 28b.	Time of Injury	м 28	Work?	at es 2 ⊡ N		l. Describe hov	w injury occurr	'ed	
Division	l or Attending atter death. Director: Atter	icat	2 Accident investigation 3 Suicide 6 Could not be		jury - At home, fa	arm. str			95 2 11		Location (Stre	eet and Numb	er or Rura	l Route Number,
Div	in Direct	Certification:	4 Homicide determined	building, e	c. (Specify)	,	oot, radiory,				City or Town,			
	spite hours merel y filler		29a. Certifier 1 Certifying Ph	ysicien: To the best	of my knowledg	e, deatl	n occurred a	t the time	, date and	place, and	due to the car	use(s) and ma	nner as st	ated.
	To the Hospitel or Attentwithin 24 hours after deating the Funerel Director: completely filled in by the	Medical	one)	niner: On the basis of and manner st	or examination are ated.	nd/or in				n occurred a		· · · · · · · · · · · · · · · · · · ·		
	Withi To the	Σ	29b. Signature and title of certifier					License			29	d. Date signed	(Month, i	Day, Year)
			nuppo					100	156	97		4/18/	104	
DI	0		30. Name and address of person who	completed cause of	death (Item 23a)	(Type,	Print)	168	7	لم مراد	-A W	L - N-		
	≺ Sta	ite	31. Date filed (Month, Day, Year)	32. <b>R</b> ∕gisti	rar's Signature	L	1	/	17	ا سر	*/ W	ر ر ر – ب	٠	
7	Registi	_	31. Date filed (Month, Day, Year) APR 2 0 20	104	wa /	Ø	Apo	uks						
N DH	MH 17 Rev 1/2	001												

456 40 4730

Wiggins Leah

	1	State of Maryland / Department of Health and I  1- State Registrar  Certificate of Death		giene2001	+ 14744
Physician		Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day Year	3. Time of Death
/Medical		Olivia Warner Wilson	April	18, 2004 4c. County of De	11:35 AM
Examiner	r	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  5441 Nithsdale Drive  Salisbury	n		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Wicomi 9. B	rthplace (State or Foreign Country)
Director		215-10-1677 1 M 20 F 93 Yrs. Months Days Hours Min.			aryland
and w	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryl f sho	2	Maryland Wicomico Salisbury			1 ☐ Yes 2 No
with the Mar s or 28e-f si the notified	2	Maryland   Wicomico   Salisbury   10e. Street and Number   10f. Zip Code	1	log. Citizen of What (	Country?
death with the Maryland ms 23e or 28e-f show rewal the notified at neveral Director	2	5441 Nithsdale Drive 21801		USA	
er dez		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	
336  urs after death v iii, or items 23e caminar must	y C	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ⚠ No   1 ☐ Yes 2 ☒ No   Specify:   3 ☒ Widowed 4 ☐ Divorced   Year or Dates:		Specify:	White
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. siem 27 is marked other than "natural", or Items 23e or 28e-f show other treumstic event, the Medical Examinar must be notified at To Re Commissed by Finneral Director	3	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work	rking	16b. Kind of Busines	s/Industry
215 ithin 7 ithin 7 Mag **	d	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	Killy		
d 21	5	12 — Bookkeeper  17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle,	Schulte	Ford
yland ould be filt Mental H Merked out marked out	ŏ	Joseph Bruce Warner Mary	Elizabe		iland
should nd Men nd Men umarke	=	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			
Mand 2 and 2 aalth a alth a ser tree		Nancy L. Ruhland (daughter) 5441 Nithsdale Drive,	Salisbu	ry, Maryla	nd 21801
Baltimore, Mapernit. Pages 1 and 2 Department of Health a Importent: If tiem 27 Is any injury or other trenone.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	r Town, State
liment lent: Pag		`4 □Donation 5XPOther (Specify)Entombment Loudon Park April	21,2004	Baltimon	e, Maryland
Ball permit Depar Impor any in	+	1. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral I	Home Prof	fessional	Association
	+	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	d, Salisk	oury, Mary	land 21804 Approximate
Bhusiaian		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):			
Examiner		Sequentially list conditions b.			
pe sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cheste of knight)			
60, be executed icien and burial-transit	Yall	that initiated events resulting in death) Last			
3760, ate be executed nysicien and the burial-transit	200	d			
68 difficat ng phy as th					
Vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certifica ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it firsation: To Be Completed by Physician/Medification:	a la	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d Month	elivery Day Year
O. E. ne dear the at the at for hed for hed for hed for hed for the at t	2	1 Yes 2 No 9 Unknown 5 Other (specify)		World	buy 1 out
P.O. that the ed by the detache	=	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds, puires the signer alid be d	5	Failure to thrut	1 🗆 Y	es 2□No 3□F	Probably 4 Unknown
H Record: The law requir cate has been s page 2 should	S S		24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
The la	5		autops perfori	med2 death?	
Division of Vital Records,  To the Hospitel or Attending Physicien: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be Medical Certification: To Re Completed by	9	evaminar?	ith (Check only or		
Physic of this of all direction of the contraction	2	1 ☐ Yes 2 Ø No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H			ecity)
ding fall		27. Manper of Death 1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation  28a. Date of Injury 28b. Time of Injury Work? 1 ☐ Yes 2 ☐ No	28d. Describe no	ow injury occurred	
Attendation of the	20	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office		reet and Number or F	Rural Route Number,
Division of the or Attending P is after death.  el Director: After the director is the funera contract of the funera contract of the funera contract of the funera contract of the funera contract of the funera contract of the funera contract of the funeral contract of th	i e E	4 ☐ Homicide determined building, etc. (Specify)	City or Town	n, State)	
ospite hours by filte	- E	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	, and due to the c	ause(s) and manner a	is stated.
Diversities of the Hospitel or within 24 hours affer to the Funeral Direction completely filled in Madical Cert	Day.	one) and manner stated.			
To vit	-	29b. Signature and title of certifier  29c. License number  D320/9	2	9d. Date signed (Mor	un, Dey, Year)
1. NO	-			4/20/04.	
O TX		MAMESH Monusha 106 MILENVA 54 504 B	54/13	BUNGA	1021804
State	2	31. Date filed (Month, Day, Year)  32. Registrar's Signature	( , -		
Registrar	7	APR 2 0 2004 Server 25 Seportes			
DHMH 17 Rev 1/200	11				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 14745 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Betty Ann Wilkerson 0630 14 2004 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 200 Terrapin Grove Stevensville Oueen Anne 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Months 1 M 2 KF 213-34-6953 Director 67 Sept 8,1936 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Queen Anne Stevensville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö or Items 23a 200 Terrapin Grove U.S. 14. Race - American Indian, 21666 filed within 72 hours after death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 ₩idowed 4 Divorced Black "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Assistant Medical Care other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9008. 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clifton Turner Bessie Hynson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Smith/neice 117 Rustic Acres Lane, Queenstown, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Robinson A.M.E. Cem. | 4/21/2004 Grasonville, MD 21. Signature of Fur eral S-rvice I ---- ee 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

21801

21801 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 €(No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2€No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 2 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of cartifier 29d. Date signed (Morith, Day, Year) 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 2540 31. Date filed (Month, Day, Year) 32. Registras Signature State 16 2004 Registrar

ORIGINAL

			1 - State Registrar		aryland / De	partment of ertificate of	Health and M Death		Reg. No.	004	14746
	Physici /Medic		Decedent's Name (First, Middle,	RALPH WI	LBURN W	AGNER		2. Date of Dea Month APRIL	14, 2	9 Year 0 0 4	3. Time of Death 3:15 PM
	Examir Funeral		4a. Fecility Name (If not institution, GENESIS ELDER  5. Social Security Number 6	CARE Sex 7. Ag	e (In yrs. last birtho	RANDAL	If Under 24 Hrs.	8. Date of Birt (Month, Da	BA	LTIMC 9. Birthp	lace (State or Foreign
	Director		217-58-8526  Usual Residence of Decedent  10a. State 10b. County	<b>1</b> 2 M 2 □ F	50 Yrs	.	110010	9/30/	1953	MARY	* *
	a Maryla Sa-f shov	Director	MD. BALTII	MORE	PIKES						1 ∐ Yes 2½Ž No
4	death with the Maryland ms 23s or 28s-f show r must be notified at	ai Dire	10e. Street and Number 4605 B OLD CC	URT RD.		10f. Zip Code 2120	8		10g. Citizen d US		itry?
	or Ita	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 If Yes, Give Year or Dates:	Ever in U.S. No1 9 7 0 1 9 7 3	Was Decedent of If Yes, specify Cul     □ Yes 2 No.	Hispanic Origin? (Spe pan, Mexican, Puerto I Specify:	ecify Yes or No- Ricen, etc.)		ace - Americ lack, White, cify: WHI	etc.
612	than than	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12) 1 2		16a. De (G lii	e. DO NOT use retire	during most of working		16b. Kind of	Business/Ind	ustry
	should be filed nd Mental Hygi marked other matic event, it	To Be Co	17. Father's Name (First, Middle, La				18. Mother's Name	(First, Middle,	Maiden Sum		
, Z	I and 2 s Health ar em 27 ls ther trau		19a. Informant's Name/Relationship VIRGINIA A • WX  20a. Method of Disposition		GHTER 33	3 WALGRO	D		-	VN, M	D. 21136
Dallimon	permit. Pages Department of Important: If it any injury or o		1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Service Light)	city)	ALL COU		ATION 4/		SYKES	SVILL	E, MD.
00/00,	Physician by Assection and by Assection and by Assection and street transit tr	fedical Examiner	23a. Part 1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I be a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as	a consequence of): a consequence of): a consequence of): a consequence of):	enter the mode of dy	MAIN ST., ing, such as cardiac o	r respiratory ar	rest,	R, MD	. 21157 Approximate Interval Between Onset and Death
YOG .O.	wequires that the death certification is signed by the attending particular be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	ey .			Date of delive Month	ory Day Year
cords, r	seen signed	by	Part II. Other significant conditions	contributing to death b	١.,	e underlying cause gi	ven in Part I.	1 🗀 Y	es 2⊞No		ably 4 Unknown
אוומו חפכ	s certificate has b lirector, page 2 s	e Completed	25. Was case referred to medical				26. Place of Death		med? 2 No	prior to cor death? 1 Yes	psy findings available npletion of cause of
DIVISION OF VICE THE COLORS, F.O. BOX Of	Attending Filystolen: The st death.  ector: After this certificate he by the funeral director, page	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigal 2 Accident 6 Could not determine	28a. Date of Inju (Month, Da	y Ye <i>ar)</i> Inju ury - At home, farm,	e of 28c. Inju	her: 4 Norsing Hon iny at 2 ork? ] Yes 2 No	ne 5 🗌 Resid 28d. Describe h	ence 6 00 ow injury occ	urred	() I Route Number,
j 5	vithin 24 hours after death.  To the Funeral Director: A completely filled in by the fo	edical Cer	29a. Certifier 1 Delifying (Check only 2 Madical Ex	Physician: To the best eminer: On the basis o	of my knowledge, d	eath occurred at the t	ime, date and place, a opinion, death occurre	and due to the d	ause(s) and r	manner as st	ated.
	10	Med	29b. Signature and title of certifier	and manner st	ared.		se number	. 1	29d. Date sign	ned (Mpnth, I	Day, Year)
(N	171 NA	ite.	30. Name and address of person where ROBERT B. KROO 31. Date filed (Month, Day, Year)	PNICK 4	4000 OLD	COURT F	RD.,SUITE	300,E	PIKESV		21208 , MD.
DНМ	Registr H 17 Rev 1/2	ar	APR 1	6 2004	en B	Sperie					

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene? 14747 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month April 2004 5:30 William Morgan Ward 10, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1 aKOMa Park

If Under 1 Year | If Under 24 Hrs.

Wonths Days Hours Washington Adventist Hospital Montgomery 8. Date of Birth (Month, Day, Year, June 28, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months 82 Director 579-10-7295 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or itams 23s or 28s-f show other traumatic event, the Nedical Examinar must be motified at 1 ☐ Yes 21 No Director Maryland | Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 2719 Terrapin Road 20902 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. XYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1942-45 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
snt: If item 27 is marked other then Electrician **Electrical** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Morgan Ward, Sr. Lorena Hodges 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2719 Terrapin Road, Wheaton, MD 20902 Theresa S. Ward/ Wife 20b. Place of Disposition (Name of complete, crematory or other place)
Parklawn Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State tment of 1 Burial 2 Cremation 3 Removal from State April 16, = 5 permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 2004 Rockville, Maryland 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 101/2 MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Due to (or as a consequence of) resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last meumone Due to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical phys the use as IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the detached 9 Unknown Hospital or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2□ No 1 ☐ Yes 2/2/No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 | Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after deathuneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Physici	an	Decedent's Name (First, Middle, L.	Day Year								
/Medical Examiner		4a. Fecility Neme (If not institution, g	JOHN SAMUEL	WIKE	4h Cihi Taur	or Location of De	APRIL 7,		7.40		
		145 WILLOWDALE DI			FREDE	RICK		4c. County of Death FREDERICK			
Funeral Director		212-64-7620	Sex 7. Age (In y 1⊠M 2□F 48	Yrs. last birthday).	If Under 1 Year Months Days				rthplece (State or Fo country) MARYLAND		
show	2	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo			<u></u>		10d. Inside City L		
23a or 28a-f shows that the notified at	Director	MARYLAND FR	EDERICK		10f. Zip Code	REDERICK		10g. Citizen of What Co			
within 72 hous alles death with the Maryland than "natural" or items 23a or 28a-f show ha Modical Examiner must be notified at	Funeral	11. Marital Status	DALE DRIVE #13  12. Was Decedent Ever in Armed Forces?		Vas Decedent of Yes, specify Cut	21702 Hispanic Origin? pan, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	UNITEI 14. Race - Am Black, Wh			
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giene. or than "nat	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	DO NOT use retire	i during most of w ad)	vorking 16	b. Kind of Business			
		17. Father's Name (First, Middle, Lat	st)		PAI	NTER 18. Mother's N	ame (First, Middle, Ma		RACTING		
r and 2 should be the fleet of the street the marked other other treumatic event,	To Be		NALD GENE WIKE					E A. MYER			
lith and 27 is m 27 is m r treum		19a. Informant's Name/Relationship MARJORIE WRENN/ N			_		Rural Route Number, C				
of Health If item 27 is		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	20	b. Place of Dispo-	sition (Name of			c. Location - City of			
Department of H Importent: If ite any injury or ot		* 4 □ Donation 5 □ Other (Spec 21. Signature of Fureral Service Lic	C C	REMATORI	UM INC.	12	. 2004	BETHESD MPHREY FU	MEDAT HON		
8818		June )	yelent MOO3	335 BE	THESDA,	<u>MARYLAND</u>	SE, INC. 7. 20814-350				
nysician		23a. Part1. Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each line.  Alcohol and				ac or respiratory arrest	,	Approximate Interval Betwee Onset and Deal		
/Medical xaminer		resulting in death)	Due to (or as a cons	sequence of):							
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury)									
ysician and	cal	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):							
ed by the attending ph detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnand Other (specify)	у		23d. Date of de Month	livery Day Year		
signed by	d by Ph	Part II. Other significant conditions  Cocaine use	contributing to death but not	resulting in the un	nderlying cause gr	ven in Part I.	23e. Did tobad	\	o use contribute to the cause of death?		
Attention of the form of the form of the form of the formula of the form of th	omplete						24a. Was an autopsy performed	d? prior to	utopsy findings avai completion of cause		
certificate rector, pag	BeC	25. Was case referred to medical examiner?					eath   Check only one	110 02100	20110		
h. After this certific funeral director,	n: To	1 No 2 No 2 No 27. Manner of Death	Hospital: 1 Inpatient 2  28a. Date of Injury  4-/Month, Day Year	her: 4□ Nursing ry at rk?	ursing Home 5 ☐ Residence 6 Q Other (Specify) 28d. Describe how injury occurred						
within 24 hours after death.  To the Funerel Director: All completely filled in by the fur	Certification;	1 Natural 5 Pending investigati 3 Suicide 4 Homicide Could not determine	Yes 2 No	Unknown  281. Location (Street and Number of Funal Boule Number of Funal Boule Number of Fundale United Streets (Maryland)							
Ed hours Funerel tely filled	edical C	29a. Certifier (Check only one)	found at hos	knowledge, death	occurred at the ti	ime, date and pla opinion, death oc	ce, and due to the caus	se(s) and manner a	s stated. e to the cause(s)		
		29b. Signature and title of certifier	and mainer stated.		29c. Licen	se number	29d.	Date signed (Mont	h, Day, Year)		
within 2 To the	Σ		Greenberg		$\sim$	ME	מא	RIL 7,200			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** April 2004 George Eliot Wilder 6:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1⊠M 2□F Yrs. Director 579-07-6270 94 Massachusetts Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō terna 23a 4810 Aspen Hill Road 20853 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married 5 Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer 4 Federal Government ortant: If item 27 is marked other injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Percy Wilder Florence Nielsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If Itam 27 is
any injury or other trau Bernice J. Wilder/ Wife 4810 Aspen Hill Road, Rockville, MD 20853 20b. Place of Disposition (Name of competery, crematory or other place Parklawn Memorial 20a. Method of Disposition April 12, 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 ans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Little of underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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		V-18-	1 - For State Registrar	State of Ma	arylar	nd / Depa	artmen rtificat	t of H	ealth ar	nd Me	ental Hy	/gien Reg. N	e200	. 147	50	
	Physici /Media	cal	Ann Burwell Winterbottom April 12, 2004										8:30 a	ath M		
	Examir Funeral Director	ner	4a. Facility Name (If not institution, given Sunrise Assisted 5. Social Security Number 229-34-7830	Living Of		ville last birthday) Yrs.	Roc	kvil 1 Year Days	If Under 24		8. Date of Bi (Month, Da May 31	Mo	Montgomery  Year) 9. Birthplace (State or Foreign Country) 1929 Virginia			
D	D	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD • Montgom	ery		ty. Town or Lo					iay 51	, 1.	727   11	10d. Inside City L		
	h with the		10e. Street and Number 11913 Renwood L	ane			10f. Zip 20	Code 852				-	itizen of What C	Country?		
<b>036</b> urs after death	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. is marked other than "natural", or Itama 23a or 28a-f ahow aumatic event, Itle Macingal Examiner must be notified at	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 25 h If Yes, Give Year or Dates:			Was Decedif Yes, spec		spanic Origin, Mexican, I	n? (Spec Puerto R	ify Yes or No ican, etc.)	0-	14. Race - Am Black, Wh Specify:			
Maryland 21215-0036	filled within 72 hc I Hygiene. other then "neturent, II e Maylon	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ide completed)	completed) (Give				uring most o	of working	16b. Kind of Business Theatre			s/Industry		
yland	ould be file I Mental Hy varked other	To Be	17. Father's Name (First, Middle, Last, John Burwell						F1orer	nce (		ine	Hutton			
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box 68/60, death certificate be executed  a attending physician and dor use as the burial-transit	Physician // Medical Examiner projection and projection in	Ical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and land land land land land land land	plications that caused one cause on each lir  a. Myocard Due to (or as b). Due to for as c Due to (or as c	ial a conseq	Infarc uence of):	er the mod							Approximate Interval Betwee Onset and Dear	n th	
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ecords, P	The law requires that the te has been signed by thi vage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Senile Dementia  1   Yes   2   No   3   Property in the underlying cause given in Part I.													
Of VItal Physician: this certifica al director, p	10 □	Completed	Anemia								24a. Was an autopsy performed?  1 ☐ Yes 2 ☑ No				lable a of	
	Phy this ald	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 XNo  27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 December 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?					r: 4 🗔 Nursii	Death (Check only one)  ng Home 5  Residence 6  Other Scriy)  1  1  1  1  1  1  1  1  1  1  1  1  1				ssisteng		
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Empletely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined							-	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
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	3(2)	M	29b. Signature and title of certifier  29c. License number 031839								29d. Date signed (Month, Day, Year) April 14, 2004					
2			30. Name and address of person who Christopher C. Dur	nford, M.D	. 61.	5 W. Mo	ontgo	,		Rock	ville,	, MD	20850			
h	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 6 2	32. Registra	r's Signa	iture &	Sp	ock.	21							

			For State Registrar		of Maryland	/ Depa	rtment of tificate o	Health a f Death		P	leg. No.	004		751	
П	Physici	an	1. Decedent's Name (First, Middle, Last)  Paby Wolfsor							2. Date of Death Month Pay Year 3. Time of Death					
>	/Medic		Baby boy Was 4a. Facility Name (If not institution, give				4b. City, Town	, or Location of	of Death	04	4c. Cc	200 dounty of Dea		10 PM	
	LXaiiiii	Ci	Holy Cross Host				Silver	Sprin	7			ntgor		S	
	Funeral Director		5. Social Security Number 6. Se	x ⊒M 2□F	7. Age (In yrs. las	N		If Under 1 Year If Under 24 Hrs.  Months Days Hours Min. 2		B. Date of Birth (Month, Day 04/06/2	, Year)				
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Lo	cation						10d. Inside	City Limits	
	Mary a-f sh	tor	MARYLAND MONTGOME	ZRY		OLNEY							1 ₫XY	es 2□No	
	or 284	Director	10e. Street and Number				10f. Zip Code			1	l0g. Citize	n of What Co	ountry?		
	s 23a	eral	4647 WESTON PLACE		adost Ever in ILE	12.1	V Dd		0832		J.S.A		dana ladiaa		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show among injury or other traumatic avent, the Medical Example must be notified all once.	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed For 1 Yes tf Yes, Gir Year or D	2₹ No ive	i	Vas Decedento Yes, specify Ci □Yes 2117 N		gin r (Speci i, Puerto Ri	ican, etc.)	1	Race - Ame Black, Whit pecify: WH	e, etc.	•	
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	filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)				none	18. Mothe	r's Name (	First, Middle,				-	
Maryland	Wental Wental wrked	To B	SCOTT WOLFSON					NANC	CY KL	KLIPPER					
Aan,	2 sho and I Is me raume	8 9	19a. Informant's Name/Relationship (T)		1	19b. Mailin	g Address (Stre	et and Numbe	er or Rural I	Route Number	, City or To	own, State, 2	Zip Code)		
	1 and Health iem 27		KEN KLIPPER - GRAN	DFATHE	20b. Plac	e of Dispo	ALLION ( sition (Name of	- · · · · · · · ·	, UPPI			PA 1 tion - City or	9053 Town, State		
Ē	Pages mt: If it		t Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		State		ratory or other p		4/09/2			Y, MAR			
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	00	Control of Salaton Control	DA:	Name and Add NZANSKY- 70 ROCK	ress of Facility -GOLDBE	ERG ME	EMORIAL	CHAI	PELS,	INC.	1852	
8760,	Physician and // Medical Examiner burial-transit sthe printer-transit	dical Examiner	23a Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Conset										ed Death		
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rds, P	quires that n signed t uld be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☆No 3 ☐ Probably 4 ☐ Unknown				
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed									24a. Was an autopsy findings availa prior to completion of cause of death?  1 Yes 2 No  1 Yes 2 No				
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	In a made						Check only on	θ)				
	ding Physi h. After this o funeral dire	lon: To	1 Yes 2 No  1 Anner of Death 2 Anner of Death 2 Anner of Death 2 Anner of Death 2 Anner of Death 2 Anner of Death 2 Anner of												
Division of	9 ± ± = 1	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 6 Could not be building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Physical Check only one)	ner: On the ba	e best of my knowled easis of examination oner stated.	dge, death and/or inv	occurred at the estigation, in my	time, date and opinion, death	d place, and h occurred	d due to the ca at the time, da	use(s) and ate and pla	d manner as ice, and due	stated. to the cause	e(s)	
	Withi To the	ž	29b. Signature and title of certifier	. 4-		~~	29c. Licei	se number				gned (Month			
		-	Porliso Temposes MO D61097							1	HPM	4, 2	.007		
)			30. Name and address of person who co				shady	Grove	Roac	Suite	300	Rockeil	ie me	20050	
	Sta Registra		31. Date filed (Month, Day, Year) APR 1 4 200	32 B	egistrar's Signature	B	Spark		.,	, 55- 0	-		- 1111	المروس م	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jane Κ. Wyatt April 2004 8:15 P /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 M 2 F Hours 92 Director 218-07-9595 27, 1911 Oct. MA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23s or 28s-f show instriust be nutified at 1 Yes 2 □ No Director MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Russell Avenue #208 20877 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23.3 may iplury or other traumatic event, the Medical Examin ser must ance. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Andrew Krezel Victoria Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly J. Graham/Daughter 10809 Kirkwall Terrace, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State April 12 \* 4 ☐Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 2004 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Licensee Deer Park Drive, Gaithersburg, MD 20877 RACYH Approximate Interval Between Onset and Death Minutes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical **Examiner** namar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 98 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 12 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No 2 PNo 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Certification; To 1 ☐ Yes 2 ☐ No 4 Mursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 HRabert Berschle 004115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robert Birschbach, M.D., 201 Russell Avenue, Gaithersburg, MD 20877 31. Date filed (Month, Day, Year) APR 13 32. Registrar's Signature State 2004 Registrar

			1 - State AACO HEALTH DE	EPI. OMH PER	land / Depa	artmen rtificat	t of H	ealth a Death	ind M	R	g. No.	01,	14753
	Physici		1. Decedent's Name (First, Middle, Last)	1 .					1	2. Date of Deat Month April	Day	Year 2004	3. Time of Death 4:15P M
	/Medio		4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or	Location o	f Death	TOTAL		y of Death	*** 1 J F
			Anne Arundel Med	dical Cent	ter	Anı	napo	lis			Anne	aru	ndel
	Funeral Director		01 .010 .	7. Age (Ir	90 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Feb 23	1914	9. Birthp Coun N . C a	lace (State or Foreign try) FOLINA
	Maryland In show	tor	Usual Residence of Decedent  10a. State  Maryland Anne Ar	undel A	c City, Town or Lo nnapoli							1	0d. Inside City Limits  12 Yes 2 □ No
	th with the 23e or 28	al Director	10e. Street and Number 1145 Madison St	. B3		10f. Zip 2.1	Code 403			1	0g. Citizen of USA	What Coun	itry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Itams 23s or 28s-f show or other traumatic event, the Modical Explicational Learning or other traumatic event, the Modical Explicational Learning or other traumatic event, the Modical Explication	by Funeral	11. Marital Status  1 Never Married 20 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1  Yes			in? (Spe Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White, fy: B1a	etc.
Maryland 21215-0036	f within 72 ho piene. r than *natur The Modical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			dent's Usua kind of wo DO NOT u Stod	rk done di se retired)	tion uring most	of worki	ng	unite Naval	d Sta	ates
/land	2 should be filed and Mental Hygi Is marked othar raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Bish Williams							(First, Middle, M Unobta			
	and 2 sho lealth and m 27 is mu		19a. Informant's Name/Relationship (Ty) Elizabeth Willia	ms(Wife)	L145	Madi	son	St.	r or Aura B3	Annapo	lis,	Md. 2	21403
Baltimore,	permit. Pages 1 Department of Hi Important: If Ital eny injury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emoval from State	ob. Place of Dispo e seo gea. to a Par	k		<u>24</u> ⊥	-15-	·04 A	nnapo	lis,	
Ball	permit. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service License  Larry M. Re	se M0048	3 8	21 W	est	St.	Ann	Mortu	, Md.	P.A. 2140	01
1 SERVE	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	c 5/4	er the mod		, such as c	cardiac o	r respiratory arre	st,	-	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Citiesas or injury that initiated events resulting in death) Last	Due to (or as a co									
P.O. Box 6	death certif e attending ad for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pr Other (sp						ate of delive	ry Day Year
	es pe	by	Part II. Other significant conditions con  High Blossed	Pressur	<u>e_</u>	nderlying c	ause giver	in Part I.			acco use con s 2 🗀 No		e cause of death?
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:						(Check only one			
on of	ding Phys h. After this funeral di	tlon: To	27. Manner of Death 1 Natural 5 Pending	1 Anpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury		8c. Injury	4 🔲 1401:	2	ne 5 Resider			)
Divisi	al or Attanding s after death. Il Director: After id in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stri pecify)					28f. Location (Str City or Town,	eet and Numb State)	er or Rural	Route Number,
	To the Hospital or Attanding Physician: Within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physical Chack only 2 Medical Examination	ician: To the best of m ler: Un the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred restigation,	at the time in my opi	, date and nion, death	place, a	and due to the ca ed at the time, da	use(s) and ma te and place,	anner as sta and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier  Pull Reliable	no MB	,		License	604		4	d. Date signe	2000	1
			30. Name and address of person who con	Peterson	(Item 23a) (Type,	Print)		Ann	Jos.	ols h	les :	214	1
	Sta Registr		31. Date filed (Month, Day, Year)  ADR 1 3 21	32. Registrar's :	signature	hart			V				

Ryan James Wiseley Unknown 04-126 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 04-02545 1 - For Stete Registrar crn Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** A M Ryan James Wiseley April 2004 2:35 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Warren Drive at Bay Ridge Drive Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. 9ept. 9, 19 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 220-12-2066 21 1982 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 27 is marked other than "natural", or itams 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1XYes 2 □ No Maryland Anne Arundel Directo Annapolis 10g. Citizen of What Country? 10e, Street and Number 10f. Zin Code death with 21401 United States Funeral 610 Monterey Ave Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nam of Health and Mental Hygiene.
ant: if Item 27 is marked other than "natural; or Ite ury or other traumatic event, the Medical Externatory or other traumatic event, the Medical Externatory. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No White Baltimore, Maryland 21215-0036 Specify Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ဥ John K. Wiseley Connie V. Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie V. Parks / Mother 610 Monterey Ave Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or QDC®. 4/19/2004 Baltimore, Maryland Baltimore Crematory 21. Signature of Fureral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 114chel A1100 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition Multiple Injuries **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequence of) Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? certificate 1 Yes 2□No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \cancel{X}$ Other (Specify) at SCENE 1 XYes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Driver of motor vehicle which Injury 1 Natural 5 Pending 1 ☐ Yes 2 💢 No 281. Location (Street and Number or Aural Route Number, City or Town, State) Intersection of Waren Tr 2 Accident
3 Suicide 4-14-04 2:29 A death investigation within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Road and Brayridge Ave. Anne Arundel mD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m. 0 hi. O.C.M.E. April 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING 111 Penn Street, Baltimore, Maryland 21201 LI th ID 31. Date filed (Month, Day, Year) 32. Registar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 16

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 14755 For Stete Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Wolfman April Milton 2004 6:33 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hollywood
If Under 1 Year | If Under 24 Hrs. St. Mary 24295 Windy Court 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 € M 2 □ F 043-01-2688 84 July 5, 1919 New York Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or items 23a or 28a-f ehow Examiner total be notified at 1 ☐ Yes 2 ■ No St. Mary's Hollywood Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20636 USA 24295 Windy Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Commissioned Officer US Army 4 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008. Be Clara Weimer P Max Wolfman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24295 Windy Court, Hollywood, Maryland 20636 Ellen L. Wolfman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04/07/2004 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, ir bor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Year Month ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ M6 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 No 1 🔲 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Many or of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the **Director:** 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the 29c. License number H0055951 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23415 Three Notch Road, California, Maryland 20619 Jennifer Schmidt, D.O. 32. Registrar's Signature 31. Date filed (Month, Day State Registrar

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			For State	State of Ma	aryland / Dep	artment of ertificate of	Health and Me			1475			
			Registrar  1. Decedent's Name (First, Middle, Last	)		Timodic of		2. Date of Death	. No.	3. Time of Death			
	Physici		Constance Ann W					Month April 10,	Day 2004 Yeer	10:07P			
	/Medic		4a. Facility Name (If not institution, give			4b. City. Town.	or Location of Death	ipili 10,	4c. County of Deal				
	Examin	ei	21789 Oscar Hayde			Bushw			St. Mary				
٠	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthday	) If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth	9 Birt	holace (State or Foreig			
8	Director		212-62-0677	]M 2XF 5	Yrs.	Months Days	Hours Min.	(Month, Day, Youngust 1, 1	ear) Co	untry)			
	D.	Ì	Usual Residence of Decedent										
	rylar	_	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limit			
	e Ma	cto	Maryland St. Mary	''S	Bushwoo	od 				1 ☐ Yes 2 N			
	if th	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?			
	23a	ra	21789 Oscar Hayde	n Road			20618		USA				
	tems tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spec ban, Mexican, Puerto R	rify Yes or No- ican, etc.)	14. Race - Ame Black, White				
36	s afte	by F	1 ☐ Never Mamed 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2. 1 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:		Specify: Wh	pecify: White			
21215-0036	itied within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examinar must be motified at	ted t	15. Decedent's Edu (Specify only highest grad	ıcation	16a. Dece	edent's Usual Occu	ipation during most of working	16	16b. Kind of Business/Industry				
121	within and the Merican	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retire	Specialist		vernment	Education			
	Hygie ther int.		17. Father's Name (First, Middle, Last)	<del></del>		Laining D	T	(First Middle Ma	Middle, Maiden Surname)				
an	should be and Mental I smarked o	o Be	James Frederi	ck Wood.	Sr.		Agnes Lo		•				
₹	mari mati	ို	19a. Informant's Name/Relationship (T)			ing Address (Stree	t and Number or Rural		<u>-</u>	in Codel			
Maryland	th ar th ar 27 is 1 rau		Geoffrey Westbrook				en Road, Bush		-	.p code)			
	of Heath		20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, crematory or other place)  20c. Location - City or cemetary, crematory or other place)										
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan pegaminen to f Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  *4 ☐ Donation 5 ☐ Other (Specify)		1 .	rt Cemeter	April		shwood, Mary	/land			
Ball	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licens	Gardin	eli) Ma	2 Name and Addr ttingley-G O. Box 270	ess of Facility ardiner Funer Leonardtown,	al Home, P MD 20650	.A.				
	Physician /Medical Examiner		23a. Parn. Enter the disease, or complete shock, or heart failure. List only of smediate Cause (Final disease or condition resulting in death)	a. PRe b	10.		ing, such as cardiac or		-	Approximate Interval Between Onset and Death			
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	a consequence of):								
8760,	ate be e hysiciar the burit	dical	Ų,	d									
O. Box 6	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	Sc. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	cy		23d. Date of deli	very Day Year			
S, D	ires that signed b	by Pt	Part II. Other significant conditions con	ntributing to death bi	ut not resulting in the u	ınderlying cause gı	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?			
ב	w requir been si should	ted	Typerce	7510V				1 🗆 Yes	2 No 3 Pro	bably 4 Unknown			
Record	hysician: The law r his certificate has be I director, page 2 sh	De de la Cristan 1 1 24a. Was autop perfo 1 Yes								opsy findings available ompletion of cause of			
Vital	Physician: this certifica	Be	25. Was case referred to medical				26. Place of Death (	1 ☐ Yes 2 Check only one)	No 1 ☐ Yes	7			
<b>&gt;</b>	ysic direc	To	examiner? 1 ∑Yes 2 □ No	lospital: 1 🗆 Inpatie	nt 2 ER/Outpatie	nt 3□ DOA Ot	her: 4 Nursing Home	5 Residence	6 ☐Other (Spec	ify)			
on of	ding P. h. After ti funera		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	Wo	ry at 28	d. escribe how i					
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, st c. (Specify)			f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,			
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best oner: On the basis of and manner sta	examination and/or in	h occurred at the ti	ime, date and place, an opinion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)			
	To the within 2 To the complex	Mec	29b. Signature and title of certifier	and mailing sta		29c. Licen	se number	29d.	Date signed (Month	, Day, Year)			

1000

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month Day Year) 2 2004



Tour

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

114285

Physician (Modica)		Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. 2. Date of Death		3. Time of Death
/Medi		KATHLEEN W. WEBER		APRIL 13	,2004 Yeer	9:42a
Examir	ıer	4a. Facility Name (If not institution, give street and number)  16 Z 2 RIDGE ROAD	4b. City, Town, or Location of Death GREENBELT		4c. County of Death PRINCE GEX	
Funeral Director		5. Social Security Number  448-20-9454  G. Sex  1 M 2 X F  81  Yrs.  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 30,	ar) 9. Birth Cou 1922 Ok1:	place (State or Forei ntry) Ahoma
th with the Maryland 23a or 28a-f show val be notified at	Director	Maryland Prince George's Greenbelt  10e. Street and Number		10g.	Citizen of What Cou	10d. Inside City Limi 1 X Yes 2 1 h
burs after des rai', or items Exeminer m	by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	20770  Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puenc	ecify Yes or No- Rican, etc.)	S.A.  14. Race - Ameri Black, White, Specify: Whi	etc. Lte
e filed within 72 h. al Hygiene. I other then "natu vent, Ine Medical	Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  6  School  17. Father's Name (First, Middle, Last)	kind of work done during most of work DO NOT use retired) DI Teacher	ing	. Kind of Business/Ir ${ m ducation}$ (en Sumame)	dustry
permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic 200s.		Virginia Moryadas - Friend  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signal Fal Service Ligensee	ng Address (Street and Number or Rur usley Place, Bluff	ton, S.C.  Date 20c.  /2004 A.  sch's Fune	y or Town, State, Zip 29909 Location - City or To Lexandria eral Home,	own, State Virgini P.A.
Physician /Medical Examiner sthe pnular-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  HYPERIFYSIVE CARDIOVASC  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):	ULAR DISFASE			Interval Between Onset and Death
that the death certific ed by the attending p detached for use as t	by Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
t the d by the ached	٩	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		use contribute to the	
equires that the en signed by the ould be detached				-	24b. Were auto	psy findings availab apletion of cause of
n: The law requires that the ificate has been signed by the r., page 2 should be detache	Completed	Of West and the second		24a. Was an autopsy performed?	death?	2□ No
w requires been sign should be	To Be Completed	25. Was case referred to medical examiner?  1 X Yes 2 No  1 Nanner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	DOA Other: 4 Nursing Ho	autopsy performed?  14 Yes 2 h	death? 1 Yes  6 Mother (Specify iury occurred	AT SCENE
i Pite	Certification; To Be Completed	examiner?  1 X Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined experiment.	28c. Injury at Work?  M 29c, Injury at Work?  1 Yes 2 No	autopsy performed?  1. Yes 2   N (Check only one)  me 5   Residence 28d. Describe how in City or Town, Sta	death? 1 Yes  6 Mother (Specification occurred	AT SCENE
i git o	ledical Certification; To Be Completed	examiner?  1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 X Natural 2 Accident 3 Suicide Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Place of Injury - At home, farm, streed building, etc. (Specify)  29a. Certifier (Check only Medical Examiner: On the basis of examination and/or invited in the page of the page o	28c. Injury at Work?  M 29c, Injury at Work?  1 Yes 2 No	autopsy performed?  1\(\text{N}\) Yes 2 \(\text{N}\) N (Check anly one)  me 5 \(\text{Residence}\) Residence 28d. Describe how inj  28f. Location (Street a City or Town, State) and due to the causeled at the time, date a  29d. D	death? 1 Yes  6 Mother (Specification occurred	AT SCENE  Route Number,  ated. the cause(s)  Dey, Year)

State of Maryland / Department of Health and Mental Hygiene 2004 11,758 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Katherine M. Winter April 13, 2004 7:20 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Cheverly
If Under 1 Year
Months Days Prince George's Hospital 7. Age (In yrs. last birthday) 78 vrs If Under 24 Hrs. 8. Date of Birth (Month, Day, Year April 19, 5 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 🕅 F Months Hours Min. Yrs. 579-26-5925 1925 Richmond, VA Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be multiled at 1 ☐ Yes 2 No Maryland Prince George's Hyattsville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4905 66th Avenue 20784 fited within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status or ! 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson Hardware Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event DDRB. Be Floyd Wartenberg Rose Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marylinn Felker - Daughter 7111 Buchanan Street, Landover Hills, MD 20784 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland National
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/17/2004 \* 4 ☐ Donat/on 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funerat Service Ucensee 4739 Baltimore Ave., Hyattsville, MD 20781 ZICHILL Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death tmmediate Cause (Final Physician BILIARY dis see or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ITN: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Hospital or Attanding Physicien: The law requires that the death certificate be executed 18): DIABE Due to (or as a consequence of): Box 68760. Physician/Medical as the IF FEMALE: BSI. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a Ö 9 Unknown 9 Hinknown Division of Vital Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificate 2⊠ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Umpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA (his 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 -Natural 5 Pending 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the Within 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 0 mD D0050951 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riverdale MD 20855 6510 REVA. S. GILL Kenelworth Ave 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 6 2004 Registrar

			1- State ( Registrar	of Marylar	nd / De <i>C</i>	partment of F ertificate of	lealth and M Death		gier 🏖 🕕 (	۱) له	14759
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  James E. Willi	ams				2. Date of De Month April	5,2004	Year	3. Time of Death 6:00 P M
	Examir		4a. Facility Name (If not institution, give street and no Charlotte Hall Veterans	Home		Charlot	- T.		4c. County St. M.	arys	
	Funeral Director		5 Social Security Number 090-20-4153 6. Sex 1½ M 2□ F	7. Age (In yrs.	last birthda Yrs.	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July I	9,1927	9. Birth Coni	place (State or Foreign intry) necticut
	Maryland -f show lied at	tor	10a. State 10b. County Maryland St. Marys		ty, Town or arlott	Location te Hall					10d. Inside City Limits 1 Yes 2 □ No
	h with the 23a or 28a	al Director	10e. Street and Number 29449 Charlotte Hall Re	oad		104 Zip Code 20622			10g. Citizen of VU.S.A		intry?
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event. Its Medical Exam mental to invitite a marked and once.	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Dev Armed F 1 Never Married 1 Yes, G Year or I	cedent Ever in U forces? 2 No 8/17 ive 8/17	7/62	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	- 14. Rad Blad Specify	ce - Americk, White,	can Indian, , etc. Le
۷	21215-0036 d within 72 hours aft giene. er then "naturel", or the manages of the	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0·12) College	) (1-4or 5+)	(Gi life	cedent's Usual Occupive kind of work done  DO NOT use retire	during most of work d)		16b. Kind of B		
A	nd 21; tiled wil Hygien other th	Be Con	12 17. Father's Name (First, Middle, Last)		Pro	ocurement	Agent 18. Mother's Name		Civil S Maiden Suman		ce
0.	Maryland d 2 should be file th and Mental Hy ?? Is marked oth traumatic event	ToB	James Wadell Williams  19a. Informant's Name/Relationship (Type, Print)		19b. Ma	ailing Address (Street	Florence			State. Zii	p Code)
D	e, Ma 1 and 2 s Health an em 27 Is		Beth Mc Koy (Daughter 20a. Method of Disposition		2650	Holland	Drive,Hun	tingtow	n, Md. 20	639	
1490	altimore, mit. Pages 1 ar partment of Hea portent: If them y injury or othe		1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from '4 ☐ Donation 5 ☐ Other (Specify)	State	emetery, c	rematory or other place Crematory	4/10	/04	Alexand	ria,	Va.
NEC 3004	Balti permit. Departr Importe any inji		21. Signature of Funeral Service Licensee	A		22. Name and Address 1500 W. B	<sup>ss of Facilit</sup> Ever raddock R				
0	Physician /Medical		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)  Due to	caused the deat each line. A L y L C (or as a conseq	im		ng, such as cardiac c	-1	rest,		Approximate Interval Between Onset and Death
Well	Examiner	iner	Section that if lifet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a conseq	uence of):						
8	18760, cate be executed physician and ithe burial-transit	dical Examiner	that initiated events	(or as a conseq	uence of):						
MEN	I Records, P.O. Box 6 The law requires that the death certific the has been signed by the attending p age 2 should be detached for use as	Completed by Physician/Med	23b. Was decedent pregnant	utcome of pregna birth 2 Feta nant at time of d nown	death :	3 □Ectopic pregnancy 5 □ Other (specify) _	,			te of delive	ery Day Year
17	cords, P.  Tw. requires that the speed signed by should be detailed.	by Ph	Part II. Dther significant conditions contributing to	death but not res	ulting in the	underlying cause giv	en in Part I.		obacco use cont	ribute to tl	he cause of death?
4	of Vital Record Physicien: The law requir this certificate has been s ral director, page 2 should	pietec	- Confide st					24a. Was a			opsy findings available impletion of cause of
iO		Be Con	25. Was case referred to medical				26. Place of Death	perfor 1 ☐ Yes	2010 1	death? I □ Yes	2☑No
B	of Vi	မ			ER/Outpat		er: Nursing Ho	me 5 🗆 Resid	lence 6 🗆 Oth		( <del>y</del> )
MA	Division of Vital or Attending Physicien: after death. Director: After this certification by the funeral director, in by the funeral director,	cation	2 Accident investigation	of Injury oth, Day Year)	28b. Time Injun	y Wor M 1□	yat k? Yes 2 □ No	28d. Describe h	low injury occur	ea	
17	Division Attraction At	Certification:	3 Suicide 6 Could not be determined 28e. Place build	e of Injury - At ho ding, etc. <i>(Specit</i>	ome, farm, y)	street, factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Rura	al Route Number,
	Division of Vita with a Hospital or Attending Physicien: within 24 hours after dear Attentis certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the and mai	e best of my kno basis of examina nner stated.	wiedge, de ition and/or	eath occurred at the tir investigation, in my o	ne, date and place, a pinion, death occurr	and due to the d ed at the time, o	cause(s) and ma date and place,	nner as s and due to	stated. to the cause(s)
	To the within 2 To the complete	Ä	29b. Signature and title of certifier	.D .		29c. Licens	e number 056949	2	29d. Date signed	d (Month,	Day, Year)
and	(10)		30. Name an address of person who completed cau	se of death (Item	n 23a) (Typ	S. Jo Jo 9	shi Baig	MD	7 917	) 21	0646
7	Sta Registr			egistrar's Signa	ituro	W	1	,			
N	DHMH 17 Rev 1/2	001			1						
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П	Physici	an	Decedent's Name (First, Middle, Last							Date of Death     Month	Day	Year	3. Time of Death
	/Medic		James Page War							04	11	2004	0835 A M
	Examir	ner	4a. Fecility Name (If not institution, give		_			Location of	Death			nty of Death	
			Montgomery Gener				ney					tgomer	У
7	Funeral Director		579-58-0436	DM 2□ E	60 Yrs. last birthday	Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Dey, 05 11	Year) 1943	Cour	lace (State or Foreign htry) hburg, Va.
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation						1	0d. Inside City Limits
	Aaryl	ŏ	MD Montgome	cv	Silver		Ø						1 X Yes 2 No
	28a-1	ect	10e. Street and Number	- 7	DIIVOI	10f. Zip					0:::		
	with a or	Funeral Director								16		of What Coun	itry r
	98 th	era	3408 Chiswick Cou	irt, #3G 12. Was Decedent B	Ever in II S 12	209		saania Osia	in 2 / Con	naifu Van as Na	USA	200 4-0-	an Indian
	lter d	Ë	11√2 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ N	lo	It Yes, spec	ify Cuba	n, Mexican,	Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,	
39	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	No DX	Specify:			Spec	city: Blac	ck
21215-0036	be filed within 72 hours after deeth with the Maryland hal Hygiene. ad other than *natural*, or Hems 23a or 28a-f show svent, the Medical Estariling must rulal be netilised at	bed	15. Decedent's Ed		16a. Dece	edent's Usua	it Occupa	ition		1	6b. Kind of	Business/Inc	dustry
2	n nin 7	Completed	(Specify only highest gra	de completed) Coltege (1-4or 5	lita	bo NOT us	rk done d e retired	furing most : )	of worki	ng			,
21	d with	E O	Clothentary/Secondary (0-12)	1 Yr.		inten	ance			I	eisur	e Wor	ld
ष्ट्र	should be filed void Mental Hygie marked other tumatic svent, In	Bec	17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle, M			
a	Aental Aental rked c	ToE	Joseph C. Ward					Sar	ah P	age			
Maryland	shot s ma		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ing Address	(Street a	ind Number	or Rura	l Route Number,	City or Tow	m, State, Zip	Code)
	alth a		Sarah V. Ward Mot	her	3408	Chisw	ick.	Cour	t #3	G Silver	Spri	ng, Mo	1. 20906
Je.	Itsm Itsm oth		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Narr	ne of				_	n - City or To	
E	Page ient c nt: if ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Metropo1		inor place		-13-	04 A	1exan	dria,	VΔ
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any injury or other traumatic as		21. Signature of Funeral Service Licen	S <del>00</del>		2. Name and	d Addres			rshall's			
Ö	Deperment of the control of the cont		a p may	Sun Ol					LIM.	Vashingt			
	===,		23a. Part 1. Enter the disease, or comp	lications that caused	the death. Do not en	ter the mode	e of dying	, such as c	ardiac o	r respiratory arres	st,	20	Approximate
8	Physician		shock or heart failure. List only trimediate Cause (Final		EPSIS								Onset and Death
п	/Medical		disease or condition resulting in death)	a	consequence of):								/WK
н	Examiner				HOLECMS	71715						16	Tw
	<u> </u>	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	t сопавушалов of).								
	te be executed ysicien and te burial-transif	cal Examiner	Cause (Disease or injury that initiated events	c									
o	en ar	EX	resulting in death) Last	Due to (or as a	consequence of):								
68760,		cal		d									
99	ntifica ng ph as th	Jed	IE EENALE.										
Вох	th ce endir	N/NE	230. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		DEctopic pre	annanev.				23d. D	ate ot delive	ry
	dea death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		Other (spe					٨	lonth	Day Year
P.O.	at the by the	hy	9 Unknown										
Ś	Physician: The law requires that the death certifica this certificate has been signed by the attending phraid director, page 2 should be detached for use as the	Completed by Physician/Med	Part II. Other significant conditions of	RENAL	DISEASE	2						ntribute to th	e cause of death? ably 4 Unknown
Division of Vital Record	aw requisite been 2 should	piet	ATHEROSCI	-TROTIC (	CARDIOVI	MUCH	n J	)UEA	\$6	24a. Was an	24b	. Were autop	sy findings available
Ä	The lav	E	131ABETE3	mthh!	Tus					autopsy	ed 2	death?	1
ita	ifcian: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place o	of Death	1 Yes 2	No	1 🗆 Yes	21XN0
>	ysician: is certific director,	0	examiner? 1 ☐ Yes 2 ☐ No	Hospitat: 1 Inpatier	t 2□ER/Outpatie	nt 3∏ DO	Othe	_	-	ne 5 Residen		ther (Snacihi	)
0	ding Phys	n: T	27. Manner ot Death	28a. Date of Injury (Month, Day	28b. Time o		Bc. Injury	at	~	8d. Describe how			/
0	Attending it death.	atio	1 Avatural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	М	Work	r es 2 □ No	0				
<u>Vis</u>	or Attendater deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, tarm, st	reet, tactory,	office		2	8t. Location (Stre	et and Nun	ber or Rural	Route Number,
Ö	s after safter s	Cert	4 Littornoide	bunding, etc.	(Specify)					City or Town,	State)		
	To the Hospitel or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the	edicai (	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of	f my knowledge, deat	h occurred a	t the time	e, date and	place, a	nd due to the cau	se(s) and n	nanner as sta	ited.
	the H in 24 the F iplete	edi	5.10,	and manner stat	ed.	vestigation,	ш шу ор	mion, death	occurre	id at the time, dat	e and place	, and due to	the cause(s)
	To To Com	Σ	29b. Signature and title of certifier	03/ m	>	29c.	License	number		290	I. Date sign	ed (Month, D	Day, Year)
0			100 F	0 - 1/		2	NO C	345	>		4	111/	94
1	(3)		30. Name and address of person who o	ompteted cause of de	ath (Item 23a) (Type,	Print)	000	COSLL	~	0.0	150	II mis	O PACP
			30. Name and address of person who of TST 7 N+W Hamp! 31. Date tited (Month, Day, Year)	him the	nue, Tai	Ema	Pa	di 1	ND	20917		P	
9	Sta Registr		31. Date tited (Month, Day, Year) APR 1 5 2004	32. Registra	r's Signature	2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alonzo Whitener Unpend Item #23a527 per me 1831 of 1290 partment of Health and Mental Hygiene 04 - 2610Certificate of Death Reg. No AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Alonzo Whitener April 15. 2004 8:17 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Montgomery 8. Date of Birth Dec. 10, 9. Birthplace (State or Foreign Country) DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 963 Days Hours Min 1**X** M 2□ F Yrs. Director 578-82-4446 40 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Mode i in than "natural", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at 1 XYes 2 No Maryland | Prince George's Capitol Heights Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Addison Road South 20743 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. e filed within 72 hours after o al Hygiene. other than "natural", or Iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: **Black** þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien Important: If item 27 is marked other thu any injury or other traumatic event, Iffan 2006. Construction Self-Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alonzo E. Whitener, Jr. Linda Barnett 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rochelle Wages - Friend 10310 Spring Water Lane, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/22/2004 Suitland, MD Cedar Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia Complicating Myocardial Fibrosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

YO Yes 2□ No page 2 has autopsy performed? 1X Yes 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1√Xes 2□No 2 er death. rector: After this by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accider 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEDDORE M. KI 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)
APR 2 6 2004 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 14762 For State
Registra MFND TTFM #2 PFR PHY G846 Certificate of Death Reg. No. 2. Date of DeatAPR 3. Time of Death Decedent's Name (First, Middle, Last) 13,2004 **Physician** Pauline Walker April 2004 9:20 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 29, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours Months Days 1 ☐ M 2 🗓 F 84 211-18-1892 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show or than "natural", or items 23a or 28a-f shov the Modest Examiner must be putified at 1 X Yes 2 ☐ No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4217 75th Avenue 20784 U.S.A. death Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify. 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, Item. Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Pride Nellie ပ Britton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer E. Walker - Spouse 4217 75th Avenue, Hyattsville, MD 20784 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State George Washington Cemetery 04/17/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Gasch's Funeral Home, P.A. 34739 Baltimore Avenue, Hyattsville, MD 20781 (Mane) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mocardial /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Obsir hronic attending physician and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 Other (specify) the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 Probably Unknown cate has been sig. . page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1□ Yes 12□No or Attending Physician: Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/15/04 1)48042 uruz, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green beis MD unover 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 1 2004 APR 2 Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2001 14763 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 Day Year **Physician** 552 AM LOVEJOY MASON WINSTON 16,2004 April /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner 5509 Highmount Lane Prince George's Capital Heights If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, December Birthplece (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 1 F 578-14-4620 95 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-1 show ury or other traumatic avant, the Medical Examinar must be notified at 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 □XYes 2 □ No Director Prince George's Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5509 Highmount Lane 20743 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married American Baltimore. Maryland 21215-0036 tf Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Nurse Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Letha Beckwith Levi Mason ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Garvey/Daughter 5509 Highmount Lane Capital Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages to Department of Himportant: If ite any injury or ot 1 Burial 2 XCremation 3 Removal from State 04/26/2004 ¹ 4 □ Donation 5 □ Other (Specify) Riverdale Crematory Riverdale, MD 21. Signature of Feneral Service Lice 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmm giane Cause (Final disease or condition Physician ARTERUSCIENATIC CANDIOVACULAR DISEASE 445 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): physician as the the attending IF FEMALE use 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached o 9 Unknown 9 Unknown þ ď. peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number D01852 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 103 QUEENS BURY Rel Hy GTDUlle Nel FVOR a 31. Date filed (Month, Day, Year) State APR 2 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 14764 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 6:40 2004 Chiu Nung Yuen April 10, /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Holy Cross Hospital If Under 1 Year Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Min. 1 ☐ M 2 🖾 F Hours Director 82 Jan. 22, 1922 China 216-02-1925 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location Show 10a. State onem. In them 4.1 is marked other than "natural", or floms 23a or 28a-f show injury occupier traumatic avent, the Medical Examinator must be notified at 8. 1 ☐ Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20853 4315 Aspen Hill Road death v Funeral Hong Kong 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item sny injury oc other traumatic event, the Mental once. 1 ☐ Never Married 2 X Married Specify: Asian 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Farmer None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Lo Nui Wong Ket Hui 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tak Yu Yuen/ Son 2706 Finley Street, Wheaton, MD 20902 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery April 17, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Atherosclerosis /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by pe 1 ☐ Yes 2201No 3 Probably 4 ☐Unknown Rheumatoid Arthritis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed? 2 No 1 Yes 1 Yes 2 ☑ No or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient G函 DOA s after dec... ral Director: After u... 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 X Natural 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di t反 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D27865 April 10, 2004 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) 1721 University Dlvd. Mark K. Li M.D. W., Whenton, ND 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State porks 2004 APR 13 Registrar

			1 - For State of Maryland / Dep	partment of Health and I ertificate of Death		ene 2004	14765
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Hyuk J. Yun		2. Date of Death Month April 1	Day Year 5, 2004	3. Time of Death 8:00P M
	Examin Funeral	er	4a. Fecility Name (If not institution, give street and number)  Washington Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death  Takoma Park  y) If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min.		4c. County of Deat  Montgomer  9. Birt	
t	Director	or	217-04-6813 1⊠ M 2□ F 64 Yrs.  Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	Aug. 5,	1939 Kon	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ehow aumatic event, the Medical Examinational be notified at	Funeral Director	Maryland     Montgomery     Rockvill       10e. Street and Number     14007 Eagle Court       11. Marital Status     12. Was Decedent Ever in U.S. Armed Forces?       1 □ Never Married     2 ☑ Married	e  10f. Zip Code  20853  Was Decedent of Hispanic Origin? (Sill Yes, specify Cuban, Mexican, Puerto	Un	ited Stat	es nican Indian, a, etc.
9200-91212	within 72 hours a iene. then "natural", or the Wickell Execut	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) (Gi	1 ☐ Yes 2 ☑ No Specify:  redent's Usual Occupation re kind of work done during most of work DO NOT use retired)  Chef	king	Specify: As  Sb. Kind of Business/  Food Serv	Industry
Maryland 2	d a b	To Be Co	17. Father's Name (First, Middle, Last) Unknown		ne (First, Middle, Ma OWN	aiden Sumame)	
	ss 1 and of Health item 27		Susan Yun/Spouse 1400  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Discemetery, circles	7 Eagle Court, Roc position (Name of ematory or other place)	kville, M	D. 20853 Oc. Location - City or	
Baltimore,	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licensee	Si	pe Funera 315 Lockwo lver Spri	1 Homes ood Drive	20904
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence d):	cavial Infor	-0		Approximate Interval Between Onset and Death 24 km
8/60,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Vulname Due to (or as a consequence of):  C. Quelon (or as a consequence of):  Due to (or as a consequence of):	shock			29 hic
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Records, P.	The law requires that the de ite has been signed by the a page 2 should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	
итан жес	i <b>ician:</b> The law r certificate has be rector, page 2 sh	e Completed	Hyperference Cardiovase Acute Lenel failure 25. Was case referred to medical	ular dinace	24a. Was an autopsy performe 1 Yes 2 E	d? prior to death?	topsy findings available completion of cause of
ō	Phys rthis raldi	ToB	examiner?  1 Yes 2 No Hospital: 1 npatient 2 EP/Outpati  27. Manner Death 1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time Injury	ent 3 DOA Other: 4 Nursing Ho		ce 6 Other (Special injury occurred	ify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	al Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, shullding, etc. (Specify)	ath occurred at the time, date and place.	City or Town, s	se(s) and manner as	hatete
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or and mannar stated.  29b. Signature and title of certifier	29c. License number	red at the time, date	and place, and due  Date signed (Month  Pril 16, 2	to the cause(s)  Day, Year)
R	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type Moshin Ijaz, M.D. 11119 Rockville 131. Date filed (Month, Day, Year)  22. Registrar's Signature	Print) Pike; Rockville, MI	20852		

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			1 = For State Registrar	State of M	Maryland / Depa Cea	artment of I rtificate of	lealth and Death		piene 20	04 1476	
	Physici	an	Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day Ye	3. Time of Death	
	/Medi		Ruth	Yeager				<del></del>	20, 2004	9:00 a M	
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	Funeral		5. Social Security Number 6. Se		Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs			George Birtholace (State or Foreign	
ŀ	Director		045-30-0366	□M 2 <b>Ě</b> )F	66 Yrs.	Months Days	Hours Min.	(Month, Day April 1		Birthplace (State or Foreign Country) hio	
	/land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
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	iff the	Oire	10e. Street and Number			10f. Zip Code	·	1	0g. Citizen of Wha	t Country?	
	ath w	ral	3012 Metronome Tu			20735			Jnited St		
36	permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show stry injury or other traumatic event. Ite Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ♣ Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 2 If Yes, Give Year or Dates	s? No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc. Black	
9	2 hou stura	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busin	ess/Industry	
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Maryland 21215-0036	id be fill ental Hi ked oth	To Be	17. Father's Name (First, Middle, Last) Samuel D. Reed					me <i>(First, Middl</i> e, i M <b>.</b> Floyd	Maiden Sumame)		
ary	shou a mar umat	۲	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	ng Address (Street	and Number or Ri	ural Route Number	, City or Town, Sta	te, Zip Code)	
	and 2 salth a n 27 li		Roscheta Jefferson	n/friend				Clinton,	MD 2073	5	
Baltimore,	of He of He of item	l	20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from Stat	20b. Place of Dispo cemetery, crer	sition (Name of matory or other pla	се)	Date	20c. Location - City	or Town, State	
Ē	Pag tment tant: jury c		* 4 □ Donation 5 □ Other (Specify,	)	Harmony M				Landover,	, MD	
Bal	permit Depar Impor eny in		21. Signature of Funeral Service Licens	nile	Å 5.	Name and Addre Lexander 538 Mar1b	ss of Facility S. Pope oro Pike	Funeral Forestv	Home ille, Mar	yland 20747	
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			Meno f	2 V		7/	32 V.	C. A	pril 20,	2004	
)	(4)		30. Name and address of person			,					
	Sta	te	Robert L. DeWitty		D 12164 Cen strar's Signature	tral Ave	., Ste 21	9, Mitch	ellville,	MD 20721	
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ORIGINAL

			1 - For State Registrar	State	of <b>Maryla</b> n		artment of rtificate of			/lental H	lygiene	20	04	14	767
	Physic	an	Decedent's Name (First, Midd	lle, Last)	-					2. Date of I			rear	3. Time of D	)eath
	/Medi	cal	SAUT							APRIL	16, 2	2004_		7:25P	. M
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	Funeral		HEBREW HOME OF 5. Social Security Number	6. Sex	7. Age (In yrs.		ff Under 1 Yea			8. Date of I	Birth	ONTGO			Foreian
н	Director		021106160	1(XM 2□F	86	6 Yrs.	Months Days	s Hours	Min.	DEC. 2	26, 19	917	Count MASS	ece (Stete or i try) ACHUSE	TTS
	pus *		Usual Residence of Decedent  10a. State 10b. County	v	10c Cit	ty, Town or Lo	ecation								
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	r 28a-	Director	10e. Street and Number	GUMERI	KU	OCKVILI	10f. Zip Code				10g. Citi	zen of Wh	at Count	in?	
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	r dea	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U.	.S. 13.	Was Decedent of t Yes, specify Cu		igin? (Sp			14. Race -		n Indian,	201.017
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Maryland 21215-0036	n 72 hour "natural edical E			nt's Education	Jales <u>1</u> 942-2	1	dent's Usual Occu	pation			16h Kir	nd of Busin			
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	4		23a. Part: Enter the disease, o shock, or heart failure. List fmmediate Cause (Final	t only one cause on	each line.	n. Do not ente	er the mode of dy	ing, such as	cardiac	or respiratory	arrest,			Approximate Interval Betwe Onset and De	
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8760,	death certificate be executed e attending physician and id for use as the bunal-transit	al E	, and a death, and	Due to	(or as a consequ	uence or):									
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Вох	death certific attending pl	N/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		_				2:	3d. Date of	f deliven	,	
	the atte	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 Fetal		Ectopic pregnand Other (specify) _	у				Month	D	ay Yea	ar
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>	Physici this cer al direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospitaf: 1	Inpatient 2 🗆 E	ER/Outpatient	3□ DOA Oth	hor -	-	ne 5□Res		Other (	Specify)		
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Division of	Attending Physician: r death. ector: After this certific: by the funeral director.	Icat	2 Accident investi	not be	a of Injury At he	to		Yes 2 N	100	204 1	(0)				
<u>≥</u>	after death Director:	Certification:	4 Homicide determ	ined 289. Flact build	e of Injury - At hor ling, etc. (Specify)	me, iarm, stre	et, factory, office			City or To	(Street and wn, State)	Number o	r Rural F	Route Number	4
	Hospital 24 hours a Funeral stely filled		29a. Certifier 1 Certifyir	ng Physician: To the	e best of my knov	wledge, death	occurred at the ti	me, date and	d place, a	and due to the	cause(s) a	ind manne	er as stat	ed.	
		edical	(Check only 2 Medical one)	Examiner: On the c	pasis of examinati nner stated.	ion and/or inv	estigation, in my	opinion, deat	th occurre	ed at the time	, date and p	lace, and	due to th	ne cause(s)	
	within To the comple	Σ	29b. Signature and fittle of certified	Unat	M	D	29c. Licens				29d. Date	signed (M	ionth, Da	y, Year)	. /
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			30. Name and address of person GREGORY CO	who completed cau MPTON MD				DAOIN	77777	E M	20050				,
	Sta	te	31. Date filed (Month, Day, Year)	32. [	egistrar's Signati		SE ROAD,		V.LLL	E, MD	<u> </u>				
	Registra	ar	APR 20	2004	Egglish Darley	fred .	Sports	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 14768 State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** FLORENCE ZIEGLER Apri1 2004 LEE 0110 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Berlin

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
6-24-15 Worcester Atlantic General Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ØF Yrs. PÁ Director 163-16-4928 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "neturel", or Items 23a or 28e-f show The Medical Examiner must be notified at 1 Yes 2 No Directo Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 136A Newport Bay Drive 21842 <u>USA</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 ₩Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tent: If item 27 Is marked other t jury or other treumatic event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ≥Frank P. Lee Irene Eaches 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth G. Wilson Son 36A Newpaor Bay Dr., Ocean City, Md., 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4-24 Salisbury, Md. 21. Signature of Fundral Service Licenseen 22. Name and Address of Facility Ullrich Funeral Home Berlin, Md 23a. Part T Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Uroseosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, Learn Limmedial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): burial Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner?
1 
Yes 2 No Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could nume determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and Me of certifier 29c. License number 29d. Date signed (Month, Day, Year) 153612 MO of person who completed cause of death (Item 23a) (Type, Print) thway Dr Berlin, MD 2181. 9733 Hea 31. Date filed (Month, Pay, Year) APR 23 2004 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 5, 2004 12:15 PM Altschull May Shirley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 3501 G Wedgewood Court Pasadena If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
February 20, 1936 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 YF 68 Yrs. 218-32-4414 Director MD. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other then "neturel", or items 23e or 28e-f shov treumatic event, the Medical Examinat must be rotified at Pasadena 1 ☐ Yes 2 XNo Anne Arundel MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21122 3501 G. Wedgewood Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White ğ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wiring Operator Westinghouse 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Importent: If item 27 is marked o Natalie MacBlane Sofinowski Morris Altschull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Regal Drive, Abingdon, MD. 21009 Myrna R. Scherer sister injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Christ Lutheran Cem. May 8,2004 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the diseas of complications that caused the death. Do of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home ome 5 Residence 6 Other (Specify)
28d. escribe how injury occurred 1 Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certification: Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 0 completed cause of death (Item 23a) (Type, Print) Hospital Drive, Gle 40 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 0 2004 Registrar

			Please	Type or Prir							-		
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	Physici		JAMES BRUCE	BAILEY					Month	Day	200	7 D	
	/Medio		4a. Facility Name (If not institution, gi				4b. City, Tov	vn, or Location of De	May	4c. Co	ounty of Deat	41	
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D	irector		210 /0 /103	1 <b>∑</b> M 2□F	41	Yrs.		-,-	2-15-			MD	
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<b>d 21215-0036</b> flied within 72 hours after death with the Maryland Horiane	items 23e or 28e-f show instituted be notified at		4102 OAKFORD AV	ENUE			21	215		U	SA		
r dea	or Items	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13. \	Was Deceden	of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0- 14.	Race - Ame Black, White		
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1215-0036 vithin 72 hours af	"natural',		15. Decedent's E	Year or Dates:	1		dent's Usual O			16b Kind	BI of Business/	LACK	
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	Item 27 I other tre		20a. Method of Disposition	NOLIE .	20b. Pla	_	sition (Name		DALITIO	1	tion - City or		
altimore, mit. Pages 1 ar			1  Surial 2  Cremation 3		Cel	metery, cren	natory`or othe PARK	r place)	/2004		MORE,		
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			23a. Pants. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death.	Do not ent	er the mode o	dying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between	
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<b>Box</b>	tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregr	ancy		230	. Date of deli	,	
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DIVISION To the Hospitel or Attending within 24 hours after death	To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	f examination	on and/or inv	vestigation, in	my opinion, death oc	curred at the time	, date and pla	ace, and due	to the cause(s)	
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	m		30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type,	Print)	1 / 2	i 1	/	Li		
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	is 1 and of Health Item 27 other tr		Mr. Anthony F. Bufano 20a. Method of Disposition	(Husband)	20b. Place of Disp	6 Croydon Ro		Oak, Mary	land 2120 20c. Location -		wn State
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		_ For	State of N		nd / Depa	artmen	t of F	lealth and I	•		•	11,77	12
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Baltimore,   Baltimore,   permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other pance.		20a. Method of Disposition 1 ☐ Burial 2X € remation 3	□Removal from Sta		Place of Dispo cemetery, crei	sition (Nar natory or o	ne of other place		Date		ocation - City or		
altimore mit. Pages 1 partment of He portent: If Iter y injury or oth		*4 □Donation 5 □ Other (Spec			verdale								
Ball Bermit Departimpor Importimpor any in		21. Signature of Funeral Service Lic	stin R	oys	ter Fu	neral Ho	me						
7		23a Part1. Enter the disease or co	mplications that caus	ed the dea	-13	821	14†I	h ST. N	W. WD	$C_2$	0011	Approximate	
Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	<u> </u>		-	^						Interval Between Onset and Death	n n
Physician /Medical		disease or condition resulting in death)	u	ATE as a consec		PIVE	JUM	ONIA				-	
Examiner		Soquentially list conditions	, Acau	11251	) Imr	NUN	DEF	CHENCY	SYN	DRO	ME		
1 1 4 1	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	ini			- *					
and and al-trans	Examiner	that initiated events resulting in death) Last	cDue to (or :	TB C		TOX	000	ASMOS	ک				
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Box 687  Box est	edic		d					-					
The cardination of the cardinati	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pr	regnancy	,			23d. Date of del		
O. B we dear	Physician/Medic	in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant 9☐Unknown	at time of c		Other (sp					Month	Day Year	Ì
1s, P.O. I	Ph)	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying c	ause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death	?
ds,	d by	SEVER	ZEMA	NUL	MITI	en			10	Yes 2	2□No 3□Pr	obably 4 Unkno	own
ecord law requi	Completed	RENAU	INSU	Pri (	cien	CY			24a. Was		24b. Were au	topsy findings availa	able
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Dn C Sing P	ion:	27. Manner of Death  1 ☑Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	M 2	8c. Injun Worl	yat k? Yes 2 ∐No	28d. Describe	how inju	iry occurred		
Division  lor Attending after death. Director: Afte	ficat	2 Accident investigati	be 390 Place of	Injury - At h	ome, farm, str			165 2 140	28f. Location	(Street a	nd Number or Ru	ıral Route Number,	
Div	Certification:	4 Homicide determine		etc. (Speci		, , , , ,	,,		City or To	wn, Stat	'e)		
BART LETT E ED Box 687  Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the be eminer: On the basis and manner	of examina	owledge, death ation and/or in	occurred vestigation	at the tin , in my o	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s	s) and manner as nd place, and due	stated. to the cause(s)	
To th within To th compl	Me	29b. Signature and title of certifier						e number			ate signed (Monti	h, Day, Year)	
		1	ATTEN	DING	& PHYSI	CINV	DE	52900	C	24/2	8/04		
2		30. Name and address of person wh	o completed cause o	f death (Iter	n 23a) (Type,	Print)	TO A	L AU.	+ 301	LAY	VD W CA	MD 20	7.55
Sta	te	31. Date filed (Month Vay (Year) 2	2000	atanda Ciaa	*****			/ /	201			1	
Registra		mmi 0 / Z	UU4	لتر ساعة	ature	100 B							

			1- For State of Maryland / I	Department of Health and Certificate of Death	Mental Hygien	- O O 1	14773	
4	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Charles C. Burden		05-01	ay Year	3. Time of Death 4:25 A M	
	Examir Funeral Director	er	4a. Eacility Name (If not institution, give street and number)  5. Social Security Number  6. Sex  7. Age (In yrs. last bit)	4b. City, Town, or Location of Death (March 1) 1 Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	,	NA  NA  9. Blirth	place (State or Foreign	
1215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28e-f show int, the Medical Examinar must be notified at	Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Tow  10e. Street and Number  AVENUE  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	10f. Zip Code  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puent 1 Yes 2 No Specify:  1. Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)	ipecify Yes or No- to Rican, etc.)	14. Race - Americal Black, White, Specify: Black Kind of Business/In	can Indian, etc.	
ımore, Marylan	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other t any injury or other traumatic event, III ODGs.	To Be Co	Joan Method of Disposition 20b, Place of 20b	D. Mailing Address (Street and Number or Rule)  A Hyper Street and Number of Rule Street and Number or Rule Street and Number of Street an	Ive, Battu	en Sumame)	) 21207	
/N Exa	Physician and /Medical examiner and physician and physicia	Ical Examiner	23a. Par1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ARTERY DISEASE  OFFICE PROPERTY OFFICE OFFICE OFFI			Approximate Interval Between Onset and Death	
P.O. BOX 68	sath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year	
cords, r	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	1 □ Yes 2		ably 4 Unknown	
He	The hate had age	e Completed	Hyper2 LIPI DEMIA  25. Was case referred to medical	20 D	24a. Was an autopsy performed?	prior to cor death?	psy findings available impletion of cause of	
lo u	ng Phy Ifter this Ineral d	Certification; To B	example?  1 Pres 2 No  Hospital: 1 Inpatient 2 Production 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Special North)  27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 1 Natural 5 Pending 29b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  1 Yes 2 No					
2	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	al Certif	29a. Certifier  29a. Certifier  1 Certifying Physician: To the best of my knowledge	e. death occurred at the time, date and place	28f. Location (Street a City or Town, State), and due to the cause(s	(e)	atad	
	To the Hu within 24 To the Fu	Medical	one)  Medical Examiner: On the basis of examination an and manner stated.  29b. Signature and title of certifier	29c. License number	rred at the time, date an	ate signed (Month,	the cause(s)	
	Sta	to	30. Name and address of person who completed cause of death (Item 23a) (ROBORT CONPORS, M.D. 3100 W) 31. Date liled (Month, Day, Year) 32. Registrar's Signature		LTIMORE, MO	) 21211		
-	Registr		WAN Q. 7: 2004 Server &	Sporker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $200 \, \mathrm{L}$ Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year 350 MY DONAUD **Physician** TUDG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel If Under 1 Year If Under 24 Hrs. 9. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral **№** M 2□ F 31, 1946 Director 215-54-2849 57 Aug. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or Items 23a or 28a-f show the Medical Evaninar must be notified at 1 Yes 2 No Director Maryland Harford Belcamp 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1404 Dalmation Place 21017 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Specify: Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 Shipping Shipping Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) wermit Pages 1 and 2 should be.
Department of Heath and Mental H
Important: If item 27 is mediany injury or other? Be Bodt. Taylor Norval Emylon (nmn) Weddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 West Ring Factory Road, Bel Air, MD 21014
ace of Disposition (Name of Date 20c. Location City or Town, State Emylon Weddell Bodt / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Smith Chapel U.M. Cem 5-8-04 Churchville, Maryland 21. Signature 1 Fun Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. METASTATIC COLON tmmediate Cause (Final disease or condition resulting in death) **Physician** MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physiclan/Medical as signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably → Unknown 1 ☐ Yes 2 ☐ No Completed peen Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No OBST 24a. Was an page 2 has autopsy performed? certificate 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Injury Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name and apdress of person who completed cause of death (Item 23a) (Type, Print) 1 UPPER CHESAPEAKE DRIVE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

348550

Richard

ORIGINAL

32. Registrar's Signature

		-	For State Registrar	State of Maryland / D	Depa <i>Cer</i>	rtment of H	ealth and Death		iene 2 () og. No.	04 14775					
	Physicia		1. Decedent's Name (First, Middle, Las	BEACHUM				2. Date of Deat	h	Year 5:47PM					
	/Medic Examin	al -	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locat						4c. County o	f Deeth					
			Northwest Hosp		th days)	Randalls	Stown If Under 24 Hrs	S. 18 Date of Birth	Baltim						
H	Funeral Director		5. Social Security Number 6. Social Security Number 1	Man all	Yrs.	Months Days	Hours Min			9. Birthplace (State or Foreign Country) Maryland					
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Loc	cation				10d. Inside City Limits					
	Maryl a-f sho	itor	MD	I	Balt	imore				1 X Yes 2 No					
	with the 3a or 28a	ai Director	10e. Street and Number 6811 Campfield Road 10f. Zip Code 21207				207	1	0g. Citizen of W	hat Country?					
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be multiled at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	l1	Vas Decedent of Hi f Yes, specify Cubai ☐ Yes 2X No	spanic Origin? (. n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		- American Indian, , White, etc. White					
Maryland 21215-0036	nin 72 hou n "natura Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)						16b. Kind of Bus	siness/Industry					
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and	d be fill solution that the contract of the co	To Be	17. Father's Name (First, Middle, Last)  James Russell B					t Rachel							
ary	shoul and Ma is marl sumati	-	19a. Informant's Name/Relationship (			g Address (Street a	and Number or F	lural Route Number	City or Town, S	State, Zip Code)					
e S	1 and 2 Health sm 27 thar tr		Janet Becker/niec	20b. Place o	f Dispo	sition (Name of	!	Hanover,							
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked eny injury or other traumatic evonce.		1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)												
Ball	Depar Impor eny in		21. Signature of Funeral Service Licer ROTIALD	Wade Director	St	Name and Address ate Anato lltimore,	omy Boar	d 655 W.	Baltimo	re Street					
	Physician		23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate cause (Final disease or condition)							Approximate Interval Between Onset and Death					
等	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):											
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9	ertificat ling ph) e as th	Medi	IF FEMALE:	23c. If yes, outcome of pregnancy					224 Date						
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Division of Vital Records,		Completed						autops	24a. Was an autopsy performed performed 1   Yes 2   No						
Vita	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 Minpatient 2 ☐ ER/O	utostion	nt 3 DOA Oth	ec	eath (Check only on Home 5 Reside		v (Specify)					
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1	Hospital 24 hours of Funeral stely filled	ledical Ce		hysicien: To the best of my knowledg miner: On the basis of examination ar and manner stated.											
<b>)</b>	To the To the comple	Me	29b. Signature and title of certifier	3 MD		29c, Licens	e number	1	9d. Date signed	(Month, Day, Year)					
			30. Name and address of person wnd	completed cause of death (Item 23a)	(Туре,	Print 7.	- N1	OHC							
	St: Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 7 200	32. Registrar's Signature	9	Sparks	•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12:50 **Physician** John Robert Caldwell Sr. /Medical 4b. 2007 Town, or Location of Death KOSECATE Facility Name (If not institution, give street and number) Examiner Battimore square | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 17 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 11X M 2 □ F 213-34-8122 67 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 StNo Middle River Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 31 Dogwood Drive 21220 USA or itams 23a by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married CAIAWell, John Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No SpecifyWhite 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) is marked other than 1 and 2 should be filed with Health and Mental Hygiene. **BGE** HeavyEquipementOperator 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Earl Caldwell Marie Dugan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Itsm 27 is eny injury or other trau John Caldwell / son 418 SprayIslandRoad Joppa Md 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State BayviewCRematory 5/10/04 Baltimore MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneral HomeofEssexer 300 MAce Ave. Baltimore MD 23a. Part1. Enter the disease, or complications that caused the death—to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical tp (or as a consequence of): Examiner onolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transil Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed t should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Pepatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: after death. Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hor To the Fune completely fi (Check only one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0

State Registrar Date filed (Month, Day, Year) 07 2004

Name and addres

of person who completed cause

Franklin Square Dr. Baltimore, md 2009

Box 68760,

P.O.

Division of Vital Records,

of death (Item 23a) (Type Print)

State of Maryland / Department of Health and Mental Hygiene 2004 State Registra MEND TIFM #9 PER FH C831 5/07/04 JHC ertificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1309 MAY CARROLL 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL EANDALLSTOWN RALTIMORE NORTHWEST 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 56-24-900 Yrs Director NJ Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, I've Nedical Examinating must be notified at 1 Tes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 4650 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry ntary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill nt of Health and Mental H ruing Ger 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) ame/Relationship. (Type, Print) 19a. Informant's Bence histour Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Localion - City or Town, State Date 20a. Method of Disposition Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Flushing 4 □ Donation 5 □ Other (Specify) -11-04 21. Signature of Funeral Service Licensee permit. 22. Name and Address of Facility Greene Furneral aberty Road Randallotown mo 2113 23a. Part 1. Enter the 1st ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardwoulmonary 12 minutes /Medical Due to (or as a cons vuence of): Examiner day Senso Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Metabolic and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached a Division of Vital Records, P.O. 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification; To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an rmea≀ 2 □ No 1X Yes within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2004 DO05 9736 D Desitson. m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST HOSPITAL 5401 0 LD COURT WATSON m.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra 07 2004

			1 - For State AMEND ITEM #23a P.	State of MER PHY C833	aryland 2 6/02	d/Dep /04. <b>0</b> 04	artment o	of He	ealth a Death	and M		giene	2001	a company	1477	8
	Dhysisi	-	1. Decedent's Name (First, Middle, Last)				*				2. Date of Dea Month		Year		3. Time of Death	h
	Physici /Medic	cal	EDWIN MELVI								May	4	2004	1	7:13P	M
	Examir	er	4a. Facility Name (If not institution, give s Gilchrist Cen				4b. City, Tow	wn, or I OWS		of Death		40.0	County of De Balt		20	
	Funeral		5. Social Security Number 6. Sex		ge (In yrs. I	ast birthday,	If Under 1 Y	ear	If Under 2		8. Date of Birtl	h Vanal			e (State or Fore	eign
	Director		220-05-9352 <sup>1</sup> X	X 2□F {	32	Yrs.	Months Da	ays	Hours	Min.	(Month, Day August	12,1	921	Vew Vew	York	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or L	ocation							10d.	Inside City Lim	nits
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	ath wi	Funeral Director	802 Chance Court						154				USA			
N. S.	ter de Items	-une	11. Marital Status  1 Never Married 2 Married	<ol> <li>Was Decedent Armed Forces?</li> <li>Wes 2 </li> </ol>	No WW I	S. 13.	Was Decedent If Yes, specify	t of His Cuban	panic Orig , Mexican	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)	1	4. Race - Arr Black, Wh			
131	within 72 hours after death with the Maryland within 72 hours after death with the Maryland she. then "neturel", or Items 23e or 28e-1 ahow he Madigal Examinat must be notified at	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 <b>)</b>	Хvo	Specify:			5	Specify:	Wh	ite	
6	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give	dent's Usual O	ione di	ırina most	t of workir	ng	16b. Kin	d of Busines	s/Indus	try	
3	within sne.	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	-	<i>DO NOT use re</i> Igineer	etired)				Ma	nufact	uri	na	
200	Hygir other	Be Co	17. Father's Name (First, Middle, Last)				igineer		18. Mothe	r's Name	(First, Middle,			Jui	iig	
4th, 2004@ 713PM	uld be Vienta	To B	John	Clu	ute				Mar	Ύ						
-	parifiliore, Intelligible to the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-1 ahow apprintury or other treumatic event, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (Type		_		ng Address (St					-			de)	
Cay J	T and 1 and Health Health		Cynthia Deshais  20a. Method of Disposition	DTI	20b. P	lace of Disp	urel Av	of			r Conne		ut 060 ation - City o		State	
3,0	Pages ant of nt: If it		1 ☐ Burial 2 🛣 remation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		matory or other it Cemet			5/7/0	4				ryland	
sday, Mi	mit. F partm porter y injur		21 Signature of Funeral/Service License	e //	/ 1		2. Name and A	•								
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(-	Physician		23a. Part1. Enter the disease, or comple shock, or heart failure. List only on Immediate Cause (Final disease or condition	eations that cause e cause on each l			PROSTATE			cardiac o	r respiratory an	rest,		Int	proximate serval Between nset and Death	2
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ç	oertificate be executed training physician and use as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ience of):										
3	the the	dical	d													
-	BOX 0	n/Me	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome								23	ld. Date of de	əlivery		
31	G. DG.	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			∃Ectopic pregn ∃ Other (specif						Month	Da	y Year	
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NIMO	OI VILAII F Physiclen; Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?  1 Yes 2 100 H	ospital:		CD/0					(Check only or ne 5□ Resid			1	Lasnia	0
3 3		n: To	27. Manner of Death	1 ☐ Inpati 28a. Date of Inju (Month, Da		28b. Time o	of 28c.	Injury Work	at		8d. Describe h		ther (Sp.	ecity)*	100/	-
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10	is gift of	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At ho tc. (Specily	me, farm, st	reet, factory, off	ffice		2	Bf. Location (S City or Tow	treet and n, State)	Number or F	Rural Ro	oute Number,	
F	spita ours ierel		29a. Certifier 12/Certifying Phys	ician: To the best	of my know	wledge, dear	th occurred at th	he time	e, date and	d place, a	nd due to the o	ause(s) a	nd manner a	s state	d.	
7.	o the Hos ithin 24 hr o the Fun ompletely	Medical	(Check only 2 Medical Examination)	er: On the basis of and manner st	of examinat ated.	ion and/or ir	ivestigation, in r	my opi	nion, deat	th occurre	nd at the time, o	late and p	lace, and du	e to the	cause(s)	
)	To the within 2 To the complet	Σ	29b. Signature and tribe of certifier	7	-11	4			number				signed (Mon	-		
	V		11/1/1/	mylle	ly	ord)	100	کار	000	5	/	1 St	115	, 0	20050	
	`		30. Name and address of person who co	ey C	31	23a) (Type	Print) 6701	N	. Ch	land	les St.	B	alto.	M	1206	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 0.7 2004		rar's Signal	Ly	Lon	1	/							

Cherry attent known as AHICM Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 1- State AMEND TIEM #10f PER FH G831 5/07/04 Dertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year CHERRY **Physician** AARON 1555 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 5: Na: Hosp: Fal Balfimore N/A Beltimore 0 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2□ F JAN 13 1946 MARYLAND 213-46-0016 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County BALTIMORE BALTIMORE MD 1 Tes 2 No Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number <del>21208</del> 7203 ROCKLAND HILLS DR. #405 USA - 21209

Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married WHITE 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 YDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SALES INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHERRY MATTHEW MINNIE POLSKY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MATTHEW CHERRY (SON) 1013 MAGOTHY PARK LANE ANNAPOLIS, MD 21401 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE, MD HEBREW YOUNG MEN 5/6/04 Fundal Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. PIKESVILLE, MD 8900 REISTERSTOWN RD. sa. Hard 1 Enter the disease, or complications hat code the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): tailure MO disease or con in resulting in death) Lung Caucer Nonsmall ell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify)

Physician /Medical **Examiner** 

**Funeral** 

Director

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other traumatic event, the Medical Exerciner must be notified at

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2 should be fill and Mental H

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the Maryland

72 hours after death

Box 68760.

P.O. I

Records.

Division of Vital

Hospital or Attending Physician:

within 24 hours a To the Funaral C

Examiner ician and burial-transit as the esn esn the þ Completed Be 2 Certification: After after death.

Year 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. erotic

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1 Yes 2 No 3 Probably 4 Unknown

a. Was	an
auto	psy
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Yes	2 💢
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24b. Were autopsy findings available prior to completion of cause of death?

	pe	rformed?
	1 L Ye	2 X No
26. Place of Death	Check on	y one)

28d. Describe how injury occurred

2 No 1 Tyes

25. Was case referre examiner?  1 \( \text{Yes} \) 2 \( \text{N} \) N	
27. Manner of Death	
1 Natural	5 Pending
2 Accident	investiga

investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Tes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

3 Suicide

29a Certifier

4 Thomicide

MD 00 60600

29d. Date signed (Month, Day, Year) May 4,2004

LYNN 31. Date filed (Month, Day, Year)

MAY 07 2004

Karyak 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai

		4	For Amend Item 26,2	State of Mar	aryland / Dep ii ,05/07/04dh	artment of Hortificate of L	ealth and M Death	1ental Hyg	giene2 ()	04	14780
	Physicia		1. Decedent's Name (First, Middle, La	st)	<i>(</i> : '	TI		2. Date of Dea	ath Day	Yeer,	3. Time of Death
	/Medic	al .	E 4013e	<i>U</i> .	Carrin		Landa de Dank	April	23	04 6	0655 HM
4	Examin	er	4a. Facility Name (If not institution, gir	. 1 ' 1	-1	4b. City, Town, or	Location of Death		4c. County	y or Death	
	Funeral		5. Social Security Number 6.		e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h Yanah	9. Birthplac	e (State or Foreign
	Director		218-42-6742	10 M 25%F 6	O Yrs.	Months Days	Hours Min.	August 2		Country	VA.
	DC &		Usual Residence of Decedent  10a. State 10b. County		10c. City. Town or L	ocation				10d	. Inside City Limits
	Aaryla I sho	0	MD NA		RAIT	more					1 Ses 2 □ No
	the h	rect	10e. Street and Number		011211	10f. Zip Code			10g. Citizen of	What Country	?
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	ams (	iner	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - American ick, White, etc	
36	hours after death with the Maryland ture!, or Itams 23a or 28a-f show al Exertiner raist be institled at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	Se .	1 Yes 2 100	Specify:		Speci	y: Place	V
21215-0036	d within 72 hours after death with the Marylan ilean. Itan insturel, or ltams 23a or 28a-1 show the Medical Exertinet relative indiffed at		15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ition		16b. Kind of E	Business/Indus	stry
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and	be fi	Be	17. Father's Name (First, Middle, Las	"			18. Mother's Nam	e (First, Middle,	Maiden Sum <b>⊌</b> i ∕	me) /	
Maryland	d 2 should th and Mer 7 Is marke traumatic	၉	19a, Informant's Name/Relationship	TVDB. nt)	19b. Mail	ing Address (Street a	CAITH and Number or Bur	al Route Number	ar. City or Town	. State. Zip Co	ode)
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re,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name of amatory or other place		Date	20c. Location	- City or Town	n, State
Ē	- O		1 ☑Burial 2 ☐ Cremation 3 € 1 4 ☐ Donation 5 ☐ Other (Spec		Woodha	UN Centel	ary April	29.2004	BATTIME	H W	D
Baltimor	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lio	nsee	2	22. Name and Addres	s of Facility	4		n.1.	c1 —
	707 8 9		23a. Part1. Enter the disease, or con	polications that caused	the death. Do not en	JYLIL FUR	Leval Hou	or respiratory as		almor A	pproximate
			shock, or heart failure. List only	one cause on each li	ne.	nor the mode of dying		or roopiratory as	, ,	10	iterval Between Inset and Death
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	ical E	l	,	a consequence of):						1044
Ö	ificate g phys as the	edic									
Box	leath certific attending p I for use as I	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		□Ectopic pregnancy				ate of delivery	Vana
	e deat he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown		Other (specify)			М	onth Da	ay Year
P.0	that the denet by the detached		Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to the	cause of death?
Records,	signe d be	d by	Chimic chamen		directe	, , , , , , , , , , , , , , , , , , , ,		101	res 2□No	3 🗌 Probab	ly 4 Unknown
cor	w require s been signature should b	Completed						24a. Was		Were autopsy	y findings available
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of V		ဥ	1 ☐ Yes 2 ☑ No	Hospital:			ar. 4 ☐ Nursing Ho				
		ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) Injury	Work		28d. Describe h	now injury occu	rred	
Division	or Attending after death. Diractor: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street							ber or Rural F	Route Number,
2	F # F C	Certification;	4 Homicide determine	building, et	tc."(Specify)	,		City or Tov	vn, State)		
	To the Hospital or Atten within 24 hours after deat To tha Funeral Diractor: completely filled in by the	edical (	29a. Certifier 1 Certifying F (Check only one)	hysician: To the best miner: On the basis of and manner st	of examination and/or i	ith occurred at the tim nvestigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as state , and due to th	ed. le cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	ed (Month, Da	y, Year)
)			)			Dea	494		4/09	11204	
			30. Name and address of person who	completed cause of d	death (Item 23a) (Type	o, Print)	Balhmac	MONI	24.8		
			31. Date filed (Month, Day, Year)		1 01 .						
	Sta Registi		MAY 07 2004	4. Due	4	parker					

State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Cox Lou Betty 3 May 2004 14:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel General Hospital Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yes July 11, Birthplace (State or Foreign
Country) **Funeral** Year) 1 ☐ M 2 🖾 F 1926 Mary land Director July 217-20-2892 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County worde ! Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Wedical Examinar must be notified at Stevensville 1 ☐ Yes 2 No Maryland Oueen Anne Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21666 USA 316 Cecil Road death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: if item 27 is marked other than "natural", or ite 1 Never Married 2/ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2√ No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be F. Nicklas 0t.t.oAnna ္ဌ John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Cecil Road Stevensville Maryland 21666 Milton Cox spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: If any injury or once. May 6 2004 | Glen Burnie Maryland Glen Haven Cemetery of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home P.A. <u>3111 Mountain Road Pasadena MD 21122</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COPD Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s autopsy performed? Yes 2 1 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 28a. Date of Injury (Month, Day Year) After thi funeral 28b Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 XNatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) within 24 hours a To the Funeral 6 To the Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place, and due to the cause(s) and place, and due to the cause(s) 29b. Signature of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37064 s of person who completed cause of death (Item 23a) (Type, Print) ames Chamberlain, 130 Love Pt. Rd, Stevensville, Md. 21666 31. Date filed 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 [ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Дау</sup> **Physician** MAY 2004 COLTON 9:15 A M STELLA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REISTERSTOWN BALTIMORE FUTURE CARE CHERRYWOOD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
MAR. 26, 1907 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 ☐ M 2 🔽 F 97 220-09-5961 Director MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12020 REISTERSTOWN ROAD 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) SECRETARY RETAIL other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if tiem 27 ie marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SLUTZKIN MORRIS ANNA BERKOW ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 ST. PAUL AVENUE - REISTERSTOWN, MD 21136 DAVID PINSKY / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) HEBREW YOUNG MEN CEM 5/6/2004 WOODLAWN, MD 21. Signature of unerat Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Ove suchin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thirderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-translt Due to (or as a consequence of) Box 68760 attending physicien Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate I 1 Yes 2 - No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of leath Check on one Hospital: Other: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Ursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)2712 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $\mathcal{N}$ ムカー 150 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

			1- State of Maryland / Department of Health and Me		2011	14783
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) Elmer Warren Crickenberger	2. Date of Death	og. No.  Pay 200  4c. County of Dea	•••
	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 1, 1	Year) 9. Bi	thplace (State or Foreign ountry) irginia
	filed within 72 hours after death with the Maryland Hygiene. uther then "neturel", or Items 23e or 28e-1 show ant, The Medical Examiner must be mailfied at	ctor	10a. State 10b. County 10c. City, Town or Location		·	10d. Inside City Limits 1 □Yes 2X No
	or 28	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	ountry?
	s 23e	eral	503 Delaware Avenue 21061  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec		United St	
920	urs after da el', or Item Xaminer	by Funeral	If Yes, Give 1 ☐ Yes 21x No Specify:  3 ☐ Widowed 4 ☐ Divorced Year or Dates: Korea	lican, etc.)	14. Race - Am Black, Whi	
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "neturel", or Items 23e or 28e-f show of other then "neturel", or Items 23e or 28e-f show event, I're Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	g 1	6b. Kind of Business	Andustry
	filed with Hygiene. other ther ent, ID e N				Federal G	overnment
Maryland	be d d o	To Be	Elmer Crickenberger Daisy Be	eck		
Mar	2 g 3 g		19a. Informant's Name/Relationship (Type, Print)  Dolores M. Crickenberger - Wife  503 Delaware Avenue			
ore,	les 1 and of Health if item 27 or other tr		20a. Method of Disposition 20b. Place of Disposition (Name of company of particular systems (1992) May 7a		Oc. Location - City or	
altimore,	Pages ment of I ent: If its ury or o		'4 Donution 5 X Other (Specify) Entombment Loudon Park Cemetery 2004		altimore,	Maryland
Ball	permit. Pages 1 ar Department of Hea Importent: If item any injury or other once.		21. Signatur of Funest Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Fune 421 Crain Highway S.	ral Hom	e P.A. en Burnie,	21061 Maryland
ĺ,			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Aznemers Disease  Due to (or as a consequence of):	2		8 years
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	led sit	Examiner	if any, leading to immediate Due to (or as a consequence of):  Cause (Disease or injury			
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6876	ficate by physic is the b	edlcal				
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	ivery Day Year
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Records,	The law re ate has bee page 2 sho	completed		24a. Was an autopsy perform 1 X Yes 2	prior to	itopsy findings available completion of cause of
Vital	Physicien: Th this certificate al director, pag	BeC	25. Was case referred to medical examiner?			- 2
01	Phys this ral di	- To			ce 6 Other (Spe	cify)
	ing After une	atlon	27. Manner of Death  1 Matural 5 Pending (Month, Day Year)  2 Accident Investigation  28a. Date of Injury 28b. Time of Injury Work?  1 Month, Day Year)  M 1 Yes 2 No	id. Describe nov	v injury occurred	
Division	_ 0	ertification:	3 Suicide 6 Could not be	of. Location (Stre City or Town,	eet and Number or Au State)	ral Route Number,
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and place and pla	d due to the cau f at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Mont	n, Day, Year)
			30. Name and address of person who completed cause of death (frem 23a) (Type, Print)		lay 03	3,2004
	8		30. Name and address of person who completed cause of death (flem 23a) (Type, Print)  David J. Loreck, MD Baltimore, MD Baltimor	ulevar	nd '	
	Sta Registr	-	31. Date filed (Month, Day, Year)  MAY 0 7 2004  32. Registrar's Signature  Apoult			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month Pay Year) 2004

3 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 14785 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 25 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE A UNIVERSITY HOSPITA If Under 1 Year | If Under 24 Hrs. 9 Birthplace Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. last birthday) 7. Age or Foreign **Funeral** Months Days Hours 1 □ M 2 D F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-f show other traumatic event. The Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code venue 0100 filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Be Completed by 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. IZE GRADE College (1-4or 5+) Teacher Yrs. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othi any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Chappel Molly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Rollte Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of f cemetery, crematory or other) Method of Disposition Burial 2 Cremation 3 Removal from State Woodlawn ( 4 □Donation 5 □ Other (Specify) C Greene Fuheral Service 22. Name and Address 21. Signature of Funeral Service Licensee Facility Kandalstown, MD 21132 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary arter disease **Physician** 423 /Medical Examiner (ereboro-vaser 421 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate ba exacuted 42 use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760. the attanding physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month 5 Other (specify) should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 ☐ Probably 4 DUnknown 1 Yes 2 No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has fillad in by tha funeral director, page 2 autopsy performed? Yes 2 No certificate 2 No 1 Yes 1 Yes of Vital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Thipatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Division 5 Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A м 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6-14 May Amenta MID D34974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601, South charles street, Baltimore, MD21230 CHARU MEHTA, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**输入Y 0.7 2004** 

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Donna E. DeHaven May 5, 2004 11:15 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford 38 Court Drive Joppa | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | Min. | May 23, 19 7. Age (In yrs. last birthday) 62 yrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F 217-40-0367 1941 Harford Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: if lean 27 is marked other than "natural", or liems 23s or 28s-f show ury or other traumatic event, in a Medical Emprise mail by mullipan at 1 ☐ Yes 2 ☐ No Director Joppa Md. Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21085 38 Court Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes Civo 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Completed by lf Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lucy Norris Elmer Hensley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael DeHaven/husband 38 Court Drive, Joppa, Md. 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages:
Department of the Important: If Ite any injury or of once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 5/8/04 Gardens of Faith Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 Ka 23a. P. 1. Enter the disease, or a lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metastatic ancreatic months Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year detached for 5 ☐ Other (specify) Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🗆 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA ð 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check the re and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa D45390 may 6 ta, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYO MIN (PN.D.) 8114 SANDPIPER CIRCLE #211, BALTIMORE, MD 21236 MYO MIN(M.D.) 32. Registrar's Signature 31. Date liled (Month, Day, Year) State Registrar 0 7 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) May 05, **Physician** 2004 Dillon 4:00 Nancy Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 6806 Belclare Road Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | Wonths Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) February 5,1950 Birthplace (State or Foreign Country) **Funeral** 1 M 200 Yrs. 216-54-3770 Director 54 MD. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "naturel", or items 23a or 28a-1 show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If item 27 is marked other than "naturel", or items 23s or 28s-1 show or other treumstic event, its Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Dundalk Director MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 Belclare Road 21222 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Frazier Janice Wood ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6806 Belclare Road, Dundalk, Md. 21222 Ronald R. Dillon Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. May 6, 2004 Baltimore City, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 21. Signature of Funeral Service Licenses Connectly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundlak, Md. 21222 23a. Part 1. Enter the disease, of complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hetaralic Cares I MUNTY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician by Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy õ in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown á signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ∰Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 s certificate has autopsy performed? 2 No 1□ Yes Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No P 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 1 or Attending Matural Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death filled in by the 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral E 29a. Certifier 😂 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 714 10 uchan 30. Name and address of person who completed cause of death (Kem 23a) (Type, Print) Ava BATIMUR AND 21224 = Allen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 07 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Yeer **Physician** MAY ans 2004 1: 40 PM inda /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arnol If Under 24 Hrs. Trunde are 0 If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Hours 218-38-6246 Months 1□M 2 F Days 63 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28 or 28a-f show eny Injury or other traumatic event, the Medical Examinar must he marked. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 □ No MD by Funeral Director Churchter 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1087 USA Broadwa 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1□ Yes 2No Baltimore, Maryland 21215-0020 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 13 ગ્ર 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rodneu Idwin ۵ Nancu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type, Print) dayster 1087 Broadwriter Point Rd Churchton, MD 20733 HPril 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2. Cremation 3 ☐ Removal from State Date Balto, MD 5-11-04 4 ☐ Donation 5 ☐ Other (Specify) tro remoitors 22. Name and Address of Facility 21. Signature of Funeral Service Licensee TIAM 1332 Mid Valley Dr. 3cscp, RA 18434

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEVERE DEMENTIA Examiner Due to (or as e consequence of) Examiner cate has been signed by the attending physician end page 2 should be detached for use as the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown RENAL STAGE ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has 1 Yes 2 UNO 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific; completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: ို 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and date, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name end address of persoutho completed cause of death (Item 23a) (Type, Print) Mighway Minersville, MD 21108 B601 Velexans mohit Neg 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 0 7 2004 Registrar

DHMH 16 Rev 6/95

DHMH 17 Rev 1/2001

State

Registrar

2. Registrar's Signature

2004

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			State of Maryland / Department of Health and Mental Hygiene 2004; 14.79  Certificate of Death  Reg. No.
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  MARY 4, 2004 0915 AM  AM 44 4, 2004 0915 AM
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Northwest Hospital Center Randall Stown  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
<b>E</b>	Funeral Director		5. Social Security Number 214-24-5354  6. Sex 1 Months Days Hours Min. 1 Months Days Hours Min. 1 May
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show int, the Medical Exempter must be notified at	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  MD BALTIMORE BALTMORE  10f. Zip Code 10g. Citizen of What Country?
	ath with	rai Dir	100 BRIGHTSIDE AVE. 21208 USA
9036	ours after death with the Maryla ral', or Items 23a or 28a-f shor Examiner mast be notified at	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1
Maryland 21215-0036	be filed within 72 hours lital Hygiene. Ind other than "natural", event, the McClest Ex-	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HOMEMAKER  16b. Kind of Business/Industry  OWN HOME
ryland	b la la la la la la la la la la la la la	To Be (	17. Father's Name (First, Middle, Last)  HARRY  RUTHERFORD  RUTHERFORD  FLORENCE  BREEDEN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, Ma	es 1 and 2 s of Health ar of item 27 is r other trau		MELVIN FRIED (HUS.)  100 BRIGHTSIDE AVE. BALTO., MD 21208  20a. Method of Disposition  1 Definition of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Liebosee  22. Name and Address of Facility  SOL LEVINSON & BROS., INC.  8900 REISTERSTOWN RD. PIKESVILLE, MD 21208
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):
8760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.
P.O. Box 6	the death certify the attending ched for use as	Physician/Med	FFEMALE:   23b. Was decedent pregnant   1
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of Vital Records,		e Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 No 25. Was case referred to medical
of Vit	Phys this al dir	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Division	ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 5 Pending investigation 4 Sec. Place of Injury - At home, farm, street, factory, office 5 Pending investigation 5 Could not be determined 6 Could not be determined 6 Could not be determined
Ö	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical Cert	29a. Certifier (Check only    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
)	To the within 2 To the Complei	Med	29b. Signature and title of certifier  D44505  MAY 4, 2004
	4		30. Name and address of person with completed cause of death (Item 23a) (Type, Print)  A.J. MPFRIAL Tr. MO - NWHC
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature  Apocks

			1 - For State Registrar		partment of Health and ertificate of Death		2004	14791
			Decedent's Name (First, Middle, Last,			Reg. 2. Date of Death	NO.	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	1	4c. County of Death	
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	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs	(Month, Day, Ye	ar) 9. Birthp	place (State or Foreign
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	land ow		10a. State 10b. County	10c. City, Town or	Location	,	1	0d. Inside City Limits
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	r 28g	rec	10e. Street and Number	10111111	10f. Zip Code	10g.	Citizen of What Coun	ntry?
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	ems ems	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. 13 Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	pecify Yes or No-	14. Race - Americ Black, White,	
36	s afte , or it		1 Never Married 2 Married	1 Tes 2 No	1 ☐ Yes 2 ☐ No Specify:	,,	Specify: Bla	
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g	al Hy l othe vent,	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maid	en Sumame)	
yla	Ment Ment arkec	10	Willie GALLONE		Hucy	CAKKING	fee	•
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (Ty		ailing Address (Street and Number or Ru			Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Importent: If item 27 is marked other then.  Importent: If item 27 is marked other then.  Importent: If item 27 is marked other then.  Importent: If item 27 is marked other then.  Importent: In the Madical Examination of the notified at an once.		1 Burial 2 ☐ Cremation 3 ☐ R	lemoval from State cemetery, ci	rematory or other place)	/ / .	Location - City or To	
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	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	CULAR ACCIDE	2/01		4DAY)
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587		edicai						
Box	death certific	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of deliver	rv
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of death 5	3 □Ectopic pregnancy 5 □ Other (s <i>pecify</i> )			Day Year
P.O.	at the by th tache	Physician/M	9 🗆 Unknown	9□ Unknown				
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_		Cor				performed? 1 ☐ Yes 2 2		2□ No
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on	ding Ph th: : After th s funeral	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury			ary coodinod	
Division of	f or Attend after death Director: /	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, s	street, factory, office	28f. Location (Street		Route Number,
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	the hin 2 the F	Med	une,	and manner stated.				
	5 1 ½ L ©		29b. Signature and title of certifier	lyme MD	29c. License number  RES-000	29d. C	Date signed (Month, D	yay, Year)
	1/h	-				147	120,20	209
			30. Name and address of person who co			JORE MAR	211/4-17/	21287
	Sta	te	31. Date filed (Month, Day, Year) MAY 0 7. 2004	32. Registrar's Signature	STREET BALTIA	MILE MAI	-10100	-1207
	Registra	_	MAY 07 2004	Denigra &	parks			

			For State Registrar	Ce	artment of Health and M rtificate of Death	Reg. t	40. ZUUL 14	792
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle,  Aa. Facility Name (If not institution,  Mexcus Management Management)	Grant	4b. City, Town, or Location of Death Paywe	2. Date of Death Month	Day 2004 (3. Time of ac. County of Deeth	of Death M
	Funeral Director		212-56-6857 Usual Residence of Decedent	S. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yes January 26,	1949 // (	3
e, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-1 show other traumatic event, the Medical Examiner rust be nuitified at	To Be Completed by Funeral Director	10a. State 10b. County  MD W/  10e. Street and Number  1315 My  11. Marital Status  1 Never Marned 2 Marrie 3 Widowed 4 Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Literal W W C  19a. Informant's Na e/Relationshi  John Grant	d	10/10  10/10  10/10  2177  Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerlo III Yes 2 ☑ No Specify:  dent's Usual Occupation wind work done during most of work to NOT use retired)  1 ☐ Yes 2 ☑ No Specify:  18. Mother's Name  18. Mother's Name  Summer Field  Summer Field	ecity Yes or No-Rican, etc.)  16b.  16c.	Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: Black  Kind of Business/Industry  State OF M.  en Sumame)	s 2□No
320	Department of months of the mo	Examiner	20a. Method of Disposition  1	B Removal from State Cemetery, creating the state of the	2. Name and Address of Facility Fun 1709 Tessier S	8,2004 end Senw +. Belth or respiratory arrest.	•	ite itween
Records, P.O. Box 68760,	The law requires that the death centificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Completed by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)  nderlying cause given in Part I.	1 ☐ Yes	o use contribute to the cause of of 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Unknown
vision of Vital	Attending Physician: r death. ector: After this certifics by the funeral director, p	Certification: To Be	25. Was case referred to medical examiner?  1	28e. Place of Injury - At home, farm, ste building, etc. (Specify)	ont 3 DOA Other: 4 Nursing Ho  f 28c. Injury at Work?  M 1 Yes 2 No  reet, factory, office	performed?  1 Yes 2  n (Check only one)  me 5 Residence 28d. Describe how in  28f. Location (Street City or Town, Sta	death? 1 Yes 2 No 6 Other (Specify) jury occurred and Number or Rural Route Num ate)	
	To the Hospitel or within 24 hours after to the Funeral Dir.  completely filled in	Medical	29a. Certifier (Check only 2 Medical E.  29b. Signature and title of certifier  30. Name a address of person w  31. Date filed (Month, Day, Year)	Physician: To the best of my knowledge, deat raminer: On the basis of examination and/or in and manner stated.	29c. License number  DHOPHU	ed at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s) Date signed (Month, Day, Year)  W. Y. ZWY  Mack  Lack  Lack  Lack	s)

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 3, 2004 Physician **GOLDBERG** Μ. ELSIE 11:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 HIGH STEPPER COURT #604 **PIKESVILLE** BALTIMORE If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) NOV . 12, 1911 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 ☐ F Yrs. 92 Director 220-03-4847 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examination ust be notified at 1 Yes 2 No Director MD BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1 HIGH STEPPER COURT #604 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify WHITE Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0 College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Pages 1 and 2 should be file partment of Health and Mental Hyportant: If item 27 is markad oth y injury or other traumatic event Be MOSS WILLIAM LENA TABAK 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21031 11350 MCCORMICK ROAD EP-3 SUITE 800 - HUNT VALLEY, MD DAVID GOLDBERG / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. HAR SINAI CEMETERY 5/5/2004 4 Donation 5 Other (Specify) OWINGS MILLS, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Pnysician MYOCA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. ff yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1710 24a Was an has autopsy 2 No 1 ☐ Yes Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA of this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation death. 2 Accident after death | Director: ... d in by the f 6 ☐ Could not be 3 🗌 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated ned (Month, Day, Year) 29b. Signature and title of certifier physician m ROFF CROSSROADS OWINGS MILLS MD 21/17 32. Registrar's Signature State Registrar MAY 0.7 2004

			1 - For State Registrar	State of I	Maryland	/ Dep	artment of F	lealth and N	lental Hy	giene 2	004 14	791
			Decedent's Name (First, Middle, I	Last)			Timouto or	20417	2. Date of De	Reg. No.	3. Time o	f Death
	Physici		JM			CA	2RY		Month	Day	Year	ВРМ
	/Medic Examir		4a. Facility Name (If not institution, g	rive street and numb	er)	410		r Location of Death	141210		2004 10:5 by of Death	101
	Exami	iei	THE JOHNS HOPKI				BALTIM		1		timore	
	Funeral				Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.				or Foreign
	Director		Un K Usual Residence of Decedent	1□XM 2□F	64	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 08/27	/1939	9. Birthplace (State of Country) Peoria,	11.
	ylanc		10a. State 10b. County		10c. City, T	Town or Le	ocation				10d. Inside C	ity Limits
	Mar	ţō	PA N/	Α	Red	d Li	on				1. Yes	2 No
	r 28s	<u>re</u>	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?	
	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show dical Examinar must be notified at	Funeral Director	830 Zimmerman	Road			1	7356		U.S.	Α.	
	deat ms ?	Jera	11. Marital Status	12. Was Decede	nt Ever in U.S.	13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Ra	ce - American Indian,	
9	after or Ite	3	1 ☐ Never Married 2 🔀 Married		□No				Hican, etc.)		ack, White, etc.	
ဗ္ဗ	ral',	l by	3 Widowed 4 Divorced	Year or Date	s:1962-6	63	1 ☐ Yes 2 No	<i>Sрөспу:</i>		Specia	% White	
ည	72 h	Completed	15. Decedent's (Specify only highest of			16a. Dece	dent's Usual Occup	ation	ina	16b. Kind of B	Business/Industry	
2	within ene. than "	npi	Elementary/Secondary (0-12)	College (1-4d	or 5+)			during most of work d)	9			
7	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, Ita Madical Examinar must be notified at	S		2 Years		2	ales				Employed	
Maryland 21215-0036	be fill tal H d oth	Be	17. Father's Name (First, Middle, La Steven G. Garr					18. Mother's Nam			me)	
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<u>a</u>	2 sh and Is m		19a. Informant's Name/Relationship			19b. Maili	ng Address (Street	and Number or Run	al Route Numbe	er, City or Town	, State, Zip Code)	
2	and ealth m 27		Lynn G. Garry	<u>- Wife</u>		330	Zimmerma	an Rd, F		on PA	17356	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Sta	cem	etery, crei	sition (Name of matory or other place	(e)	Date		- City or Town, State	
<u>E</u>	Pag ment ant: ury c		` ★□Donation 5 □ Other (Spec		Howa	ard .	Med. Sch	1001 04/	29/200	4 Wasl	hington,	DC
<u>a</u>	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Lic	ensee		22	2. Name and Addres	ss of Facility US	tin Ro	yster	Funeral	Home
ш_	202 2 3		* Yall			3	821 14th	n ST. N.	W. WDC	2001	1	
		_	23a. Parti. Enter the disease, or co shock, or beart failure. List on	mplications that caus ty one cause on each	sed the death. I	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximat Interval Bet	.e ween
	Physician		Immediate Cause (Final disease or condition	RESPIN	atory (	ailar	L from	hyperc	arhia		Onset and I	Death
	/Medical		resulting in death)	Due to (or	as a consequen			- 13hor	arvia		12 010	ours
	Examiner		Sequentially list conditions	, Fungal	1 Pheu	mor	na				2 W/	1165
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		as a consequen		1 . 1					
	nd	Examiner	Cause (Disease or injury that initiated events	c. Aut			LUKEN	lac			(a Mo	nths
Ó.	e be executed /sician and e burial-transit		resulting in death) Last		as a consequen		C - un also					
3760,		icai	•	a. Myelo	dyspla	stic	syndn	ome			2 410	25
99	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE:		• (						J	
Вох	th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth	ne of pregnancy 2 Fetal de		Ectopic pregnancy				te of delivery	
	the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		Other (specify)			Mo	onth Day h	Year
о. О.	that the de ed by the detached	h	9 Unknown						_			
Ś	res lha igned be del	by	Part II. Other significant conditions	contributing to death	n but not resultin	ng in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to the cause of d	eath?
ב	w requir been si should I	Completed							1 1	es 2.2 No	3 ☐ Probably 4 ☐L	Jnknown
ပ္ပ	has be	pie							24a. Was autop		Were autopsy findings a prior to completion of ca	available
<u>~</u>	The ate h page	Out							perfor	med2	death? 1 ☐ Yes 2 ☐ No	xuse or
<u> </u>	ian: ortifica ctor,	Be C	25. Was case referred to medical					26. Place of Death				
<u></u>	nysic nis ce	To	examiner?	Hospital: 1 Tinpa	atient 2 ER	/Outpatier	t 3 DOA Othe	er: 4 🗌 Nursing Ho	me 5 ☐ Resid	ence 6 Oth	ner (Specify)	
0	ng Pt Iter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, I	njury 28 Day Year)	b. Time of	28c. Injury Work	at	28d. Describe h	ow injury occur	red	
Ö	endil sath. or: A he fu	atic	2 ☐ Accident investigati	on		, ,		Yes 2 □No				
Division of Vital Records,	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	280. Place of I	Injury - At home etc. (Specify)	, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numb	per or Rural Route Num	ber,
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page											
	d hou	icai	29a. Certifier  (Check only  2 ☐ Medical Exp	hysician: To the bea	st of my knowle	dge, death	occurred at the time	ne, date and place,	and due to the	ause(s) and ma	anner as stated. and due to the cause(s)	
	the F the F the F	Medical		and manner	stated.	anaor in	ostigation, in my of	Jinon, deam occurr	ou at the time, t	ate and place,	and due to the cause(s)	1
	With To	2	29b. Signature and title of certifier				29c. License	number		29d. Date signe	d (Month, Day, Year)	
			- Xm				RE	5-000		APRIL	29, 2004	
			30. Name and audress of person who	o completed cause of	f death (Item 23	la) (Type,	Print) NADIA	VE JACK	SON, N	ID	1	
			JOHNS HOPKINS 1-	HUSPITAL	600 No	RTH	WOLFE.	STREET S	BALTIMO	RE MI	ARYLAND 2	1205
27.	Sta		31. Date filed March, Day, Year)	A2. Regis	strar's Signature						-	

DHMH 17 Rev 1/2001

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			For State Registrer		State of	Marylan	id / Depa <i>Cer</i>	rtment of F	lealth and N <i>Death</i>		giene (	004	147	195
			1. Decedent's Name (F	irst, Middle, La	st)					2. Date of De	eath		3. Time of	Death
	Physici /Medic		William	V.	L. G	ensler				May 5,	2004	Year	9:30	A M
	Examir		4a. Facility Name (If no	ot institution, giv	e street and nun	nber)		4b. City, Town, o	r Location of Death		4c. Cour	ity of Death		
		3	Gilchrist					Towson				imore		
	Funeral		5. Social Security Num	1	ex XM 2□F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)		place (State o	r Foreign
	Director		213-26-244 Usual Residence of De	-/		/	'3 Yrs.			May 19	,1930	MD.		
	land ow			0b. County		10c. Cit	y, Town or Lo	ation					10d. Inside Cit	ty Limits
	Mary -f sh	to	MD. E	Baltimor	e		Dundal	k					1 🗌 Yes	2 ₹ No
	r 28a	Director	10e. Street and Number					10f. Zip Code			10g. Citizen o	f What Cou	ntry?	
	h with	O E	1237 Delbe	ert Aven	ue			2122	2		USA			
	deat	Funeral	11. Marital Status		12. Was Dece Armed For	dent Ever in U	.S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		ace - Ameri		
	after or Ite	F	1 Never Married		1X1Yes			Yes 2XXXVo	Specify:	rican, etc.)	Spec	lack, White,	ite	
	DOG	d by	3 Widowed 4		Year or Da	ites:					3,000	.ny. VVI.		
	21215-0036 d within 72 hours aft giene. er than "naturel", or tre Medical Exerni.	Completed	15 (Specify	<ol> <li>Decedent's Endoughest grade</li> </ol>	ducation ide co <i>mpleted)</i>		(Give	ent's Usual Occup kind of work done OO NOT use retired	during most of work	king	16b. Kind of	Business/Ir	idustry	
	withir than	ф	Elementary/Seconda	ary (0-12)	College (1	4or 5+)			<i>3)</i>		T-To mbox	em 171 e		
	d 2 filed Hygi		10 years 17. Father's Name (Fin	st, Middle, Last,			Machi	nist	18. Mother's Nam	e (First, Middle	Wester		ctric	
	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene, differ 28 or 28 or 28 at show other traumatic event, it a Macical Examiner must be notified at	To Be	Frank W. G	ensler	Sr.				Margare	t M. Hu	mmel	, 		
	Mar d 2 sho th and 7 Is mu traum		19a. Informant's Name Therese Ge		Турө, Print) wife				and Number or Run Avenue, Du				code)	
	s t and of Health item 27		20a. Method of Dispos	ition		1 -	lace of Dispos	sition (Name of satory or other place	!	Date	20c. Location		own, State	
	Baltimore, permit. Pages 1 a Department of Her mportant: If item any injury or othe once.		1 Burial 2 □ C 1 4 □ Donation 5 (	Other (Specif	y)	itate	red Hear	Of Jesus	Cem. May 8		Dundal			1
	Baltimore, Misperial Pages 1 and 2 Department of Health a Important: If tiens 27 is any injury or other tra		21. Signature of Funer	ranservice Licer	1590)	mel	ly 30	Name and Addre Onnelly 1 110 Solle	ss of Facility Funeral He ers Point	ome Of Road.	Dundalk Dundalk	P.A.	21222	
			23a. Part1. Enter the c shock, or heart fa	ailure Ust only	plications that ca one cause on ea	used the deat ich line.							Approximate Interval Bety Onset and D	ween
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093	Examiner		Sequentially list condi	tions	b	71 <b>23</b> & CO11364	derice or).							
O	A Po High	niner	Sequentially list condit if any, leading to imme cause. Enter Underly Cause (Disease or inju-	ng 🚄	Due to (	or as a conseq	uence of):							
K	execut in and ial-trar	Examiner	that initiated events resulting in death) Las		c. Due to (c	or as a conseq	uence of):							
1	<b>68760,</b> Ricate be executed physician and is the burial-transit	dlcal			d									
A.	Box 6 Jeath certific	ian/Me	IF FEMALE:		23c. If yes, outo	ome of pregna	incv				004 5	1 1		
5	Box leath cert attendin	O	23b. Was decedent pr in the past 12 mo 1 \(\subseteq\) Yes 2 \(\subseteq\) N	inths?	1 ☐ Live bi	rth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pregnancy Other <i>(specify)</i>	′			ate of delive Ionth	,	'ear
7	IS, P.O.	Physi	9 Unknown	0	9□ Unkno	wn					343			
saxier, Willians	Records, P.O. Box 6 The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significa	nt conditions o	ontributing to de	ath but not res	ulting in the un	derlying cause giv	en in Part I.		obacco use co Yes 2 □ No			eath? Inknown
	Records, he law requires the law been signed as been signed as should be comedited.	ompleted								24a. Was		. Were auto	ppsy findings a	available
=	The law	Com								autor perfo 1  Yes	rmed? 2/Q No	death?	mpletion of ca 2□ No	use of
7	of Vital Physicien: The This certificate ral director, pag	Be	25. Was case referred examiner?	to medical	Hospitali				26. Place of Deat				1	1
7	hys h	2	1 Yes 2 No		Hospital: 1 ☐ Ir		ER/Outpatient	3 DOA	er: 4 Nursing Ho			ther (Specif	hospi	9
3	on ding F	lon	Matural 5	5 ☐ Pending	(Month	n, Day Year)	28b. Time of Injury	28c. injun Worl M 1	yat k? Yes 2 □ No	28d. Describe I	now injury occi	irrea		
ch -	Division  or Attending after death. Director: After	icat	2 ☐ Accident 3 ☐ Suicide	investigation Could not b		of Injury - At he	ome farm stre	et, factory, office		28f. Location (S	Street and Num	ther or Rurs	al Boute Numb	her
$\circ$	Div	Certification:	4 Homicide	determined	buildin	g, etc. (Specif	y)	ot, factory, office		City or Tov		1001 01 11012	ii rioute reamo	<i>iei</i> ,
	Division o To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	edical (	29a. Certifier (Check only one)	Certifying Ph Medicel Exer	ysician: To the niner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s) and n date and place	nanner as s , and due to	tated. the cause(s)	
	To th within To th	Me	29b. Signature and title	of certifier	0	b		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)	
	50		MAX.			M)		DS	8303		MTY	5 0	4004	
	170		30. Name and address	horl	completed cause	of death (Item	23a) (Type, F	rint)	hoples	72.	Balton	me, 1	40 à	1204
	Sta Registr		31. Date filed (Month,	Day, Year) 0 7 2004	32. Re	gistrar's Signa	ture	parks						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

The Street of Number   121 ST AGNES LANE #325   11.7 AGNES LANE *325		а	mend item #10a,f,		INF <b>Certificate of</b>			eg. No.	14 14796	
Contact Hale Little of Green Contact Hale Little of Catons ville   Catons ville		Dhysisis								
Signature Health of Catonsville  Signature Health of Catonsville  Signature Health of Catonsville  10 - 20 - 19 - 20 - 20 - 20 - 20 - 20 - 20 - 20 - 2								<del></del>	0, 2004	12:30 AM
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To State   100 Court   100 City				217-18-0059	- 100 - 100 - 1	Months   Devs		July 29	, 1921	
Rev. Joshua Henry Green    10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele and Number or Plant Floure Authority Coll DIE REESBY   10s. Mainry Address   Steele And Tony Address   Steele		Merylend f show	ō	10a. State 10b. County		•			-	10d. Inside City Limits 1 ☐ Yes 2∑ No
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Physician (Medical Examinor)    Part II. Other algorithms of the cause of least of the cause of death of the cause of the cause of death of the cause			-	23a. Part1. Enter the disease, or comp	lications that caused the deat				est,	Approximate
Medical Examinor   Medical Exa		Physician		shock, or heart failure. List only o	one cause on each line.	0	0			Interval Between Onset and Death
The state of the s		/Medical		Immediate Cause (Final disease or condition	Odvan	ed eng	Mysen	ia_		geon
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Part    Other significant conditions contributing to death but not resulting in the underlying cause given in Part	092	slclen b burie	E E	ceuse. Enter Underlying Cause (Disease or injury that initiated events	C. Due to /e	r on a company one of):				
Part    Other significant conditions contributing to death but not resulting in the underlying cause given in Part	68	g phy es the	8	resulting in death) Lest	D00 t0 (0	r as a consequence or).				
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		,	1 - For State Registrar	State of Mary	land / Depa <i>Ce</i>	artment of Horificate of E	ealth and i Death		giene 2001	14797
	Physici /Medic		Decedent's Name (First, Middle, Last	John Russ	sell Hai	ines		2. Date of Dea Month	Day Year	3. Time of Death 7: 22AM
	Examir		4a. Facility Name (If not institution, give	ore Hos	Pital yrs. last birthday)	4b. City, Town, or	Location of Death		4c. County of bear	th 1 M O C thplece (State or Foreign
	Funeral Director			ZM 2□F 51		Months Days	Hours Min.	May 15	, Year)   Co	ryland
	Maryland	tor	10a. State 10b. County	imore	c. City, Town or Lo	ocation	Essex			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	as or 288	I Director	10e. Street and Number 7 Eyring Avenue			10f. Zip Code	221	1	10g. Citizen of What Co	•
36	hours after death with the Maryland tural', or items 23s or 28s-1 show at Exter-insert be riselihed at	by Funeral	11. Marital Status  1 Never Married 28 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 Yes 28 No	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	nican Indian,
Maryland 21215-0036	s within 72 hours in the street in the stree	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occupa kind of work done do DO NOT use retired)	aring most of wor	rking	16b. Kind of Business/	Industry
ind 2	e filec of the vent,	Be	8 Years 17. Father's Name (First, Middle, Last)		GY	oundkeepe	18. Mother's Nar	ne (First, Middle, I		Corp.
Maryla	d 2 should be th and Mental 7 is marked of traumatic ev	2	John Thomas Hai 19a Informant's Name/Relationship (T) Mrs. Patricia Hair	/pe, Print)		ng Address (Street at	nd Number or Ru		r, City or Town, State, 2	
Baltimore, I	permit. Pages 1 and 2 should be Department of Health and Menta Important; if item 27 is marked any injury or other traumatic e goce.		20a. Method of Disposition   **Adurial 2 □ Cremation 3 □ F  * 4 □ Donation 5 □ Other (Specify)	Removal from State	Ob. Place of Dispo cemetery, crei		)	Date	20c. Location - City or Middle Riv	Town, State
Baltii	permit. P Departm Importar any injur		21. Signature of Funeral Service Licens		Ž.		Funeral	Home of	Dundalk, I	
	Physician /Medical		23a Part 1. Enter the disease, or comp shock, or heart failthe. List only of immediate Cause Final disease or condition resulting in death)	lications that caused the ne cause on each fine.						Approximate Interval Between Onset and Death
8760,	physician and physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor  Due to (or as a cor  Due to (or as a cor  d.	nsequence of):	nay s	syndi	w.		
O. Box 6	ne death certli the attending thed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year
0		by	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause giver	n in Part I.		pacco use contribute to	
Vital Records,	The law requires ate has been sign page 2 should be	Completed						24a. Was a autops perform	prior to death?	topsy findings available completion of cause of
f Vita	ysician: is cartific director,	To Be (	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 YER/Outpatier	05-	1/10	th (Check only on	ence 6 Other (Spec	sify)
Division of	ding After fune	Certification:	27. Manney of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		Work? M 1 □ Y	at es 2⊡No		w injury occurred	
Divi	in the		4 Homicide determined	28e. Place of fnjury - building, etc. (Sp	oecify)			City or Town		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one) 2 Medical Exami	sician: To the best of my ner: On the basis of exar and manner stated.	mination and/or in	vestigation, in my opi	nion, death occu	rred at the time, da	ate and place, and due	to the cause(s)
•	To To I		29b. Signature and title of certifier	tales		DOL DOL	544	40	9d. Date signed (Month	, Day, Teal)
	2		30. Name and address of person who co	6kotata.	9 son Fra	Print) NKlin Solu	are Dri	verolti	more, M	021237
	Sta Registr		31. Date filed (Month, Pay, Year)	34. Registrar's S	ignature	all of	·			

			1 - For State Registrer			Depar			Mental Hygie	ne2 0 0 4	14798
	Physici /Medic		1. Decedent's Name (First, Middle Ethel Lo	rraine	He	e5e1	bach	)	2. Date of Death Month	. <b>No.</b> Day Year <b>02 200</b>	1 01.00
	Examir Funeral Director	ier		Bayview Me 6. Sex 7. Agr	<b>dical</b> 9 (In yrs. last bi 78	enter	4b. City, Town, of Street Indicated the Indi	or Location of Death  A / H/MO/  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, Ye July 1		n/A  rthplace (State or Foreign country)  ryland
	e Maryland Ba-f show	Director	4	ltimore	10c. City, Tov	vn or Loca	ution Dundall	ς			10d. Inside City Limits 1 ☐ Yes 2XXIvo
9800	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examinational be redified at	by Funeral	10e. Street and Number 632 Aldworth R 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces?			as Decedent of Fres, specify Cub	21222 Hispanic Origin? (Sp an, Mexican, Puerto Specify:	υ	Citizen of What C  Inited St  14. Race - Am Black, Whi  Specify:	ates erican Indian,
d 21215-0036	ba filed within 72 hours ital Hygiene. Ind other than "natural", event, I're Medical Era	<b>Completed</b>	15. Decedent (Specify only highes: Elementary/Secondary (0-12) 7 Years 17. Father's Name (First, Middle, L	c grade completed) College (1-4or 5		(Give kii life. DC	nt's Usual Occup nd of work done O NOT use retire emaker	during most of work d)	ing 16t	Own Home	
Maryland	2 should ba and Mental is marked o	To Be	David C. Helm  19a. Informant's Name/Relationsh Brian Heselbacl	ip (Type, Print)	198			Ethel	Barrows  al Route Number, Ca	ity or Town, State,	
Baltimore, I	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to		20a. Method of Disposition  1 Denance 5 Cremation  4 Denance 5 Other (Sp. 21. Synature 8 Junes Se. 22.	3 □Removal from State		of Disposit ery, crema Jawn	ion (Name of tory or other pla Cemeter	<sub>сө)</sub> y 5/6/20	Date 200	:.Location - City or Baltimore	Town, State
	Physician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	yland 21	Approximate Interval Between Onset and Death MINUTES						
760,	Examine pe executed hysician and the burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Endo Due to (or as a	a consequence card a consequence A D a consequence	of):	eremi	a			hours Days
Вох 68	death certific e attending p ed for use as f	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 DAYO	d	of pregnancy 2 Petal death		ctopic pregnancy	y		23d. Date of de Month	livery Day Year
Records, P.O.	The law requires that the death ite has been signad by the atter bage 2 should be detached for i	ted by Phys	9 ☐ Unknown  Part II. Other significant condition  CHF, HTN		It not resulting i	n the unde	erlying cause giv	ven in Part I.			o the cause of death?
ital Rec	tian: The law artificate has bottor, page 2 sh	Be Completed by	25. Was case referred to medical examiner?					26. Place of Deat	24a. Was an autopsy performed 1  Yes 2  2  2  2  1	prior to death?	utopsy findings available completion of cause of 2 No
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification; To I	1 Yes 2 No  27. Manner of Death  1 Actural 5 Pending investigations	ation		utpatient Time of Injury	28c. Injur Wor	v at	me 5 Residence 28d. Describe how in		cify)
Divi	Hospital or Att 24 hours after d Funeral Direct stely filled in by (	edical Certific	3 Suicide 6 Could nedetermin  29a. Certifier Check only 2 Medicel E		. (Specify)  f my knowledge	e, death o	ccurred at the tir	ne, date and place,	28f. Location (Street City or Town, St	e(s) and manner as	stated
	To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	Dolding	ted.		29c. Licens	e number	29d.	Date signed (Mont	h, Day, Year)
	5 Sta	te	30. Name and address of person w  Amit Golding 31. Date filed (Month, Day, Year)	3,MD -	eath (Item 23a) 4940 2 r's Signature	(Type, Pri	tern f	fuenue,	Baltime	ore, MD	21224
	Registr		MAY 0 7	2004	مولی مختامر مسا	200	all of				

State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ENCP HARGYOVE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TUNNP BOH MOVE Date of Birth (Month, Day, If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F -46-9915 Months Hours Min. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Kaltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21207 6724 )RIVE Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No by Specify Specify: 3 Widowed 4 ☐ Divorced "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondan ndary (0-12) attimore nauneer Department of Health and Mental Hygie Important: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Fowlke ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (T e, Print) 20b. Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 0 Boyd Family Cemeter \* 4 □ Donation 5 □ Other (Specify) 'hoseCH OSECHY VF eene Fuhera f Facility Oughn permit. 21. Signature of Funeral Service Licensee 22. Name and Address any ir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** leave /Medical Examiner aRC ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): the attending physicien Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo Year Month Day 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ M6 detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe calfbrillation 4 Gonknown 2 🗆 No Completed 1 TYes 3 Probably page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 Ko 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Des vibe how injury occurred 1 Natural 5 Pending To the mospoor within 24 hours after death.

To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 \_\_\_\_\_\_rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 101 63X WI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M no 30 a 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **端AY 07 2004** Registrar

		4	1 - For State Registrar	State of M	laryland / Depa	artment of H			2009	14800
			Decedent's Name (First, Middle, Las	t)				2. Date of Deat	<b>eg. No</b> . h	3. Time of Death
	Physici	an		DORMAN	HOWELL			Month	5, 2004 Year	
,	/Medic					4h Cihi Toura or	Longtion of D		4c. County of Death	10:40 A.M
	Examir	er	4a. Facility Name (If not institution, give		,	4b. City, Town, or		eatn		
			Gilchrist Cenete			Tows		Iron I I and	<u>Baltimo</u>	
п	Funeral		5. Social Security Number 6. Se	x □M 21∑7F / A	ge (In yrs. last birthday) 69 Yrs.	Months Days	Hours N	fin. (Month, Day,	Year) 9. Birth	place (State or Foreign
	Director		213-30-2071	-X	09 115.			May 29,	1934 Mar	yland
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	aryla sho	2								1 ☐ Yes 2 X No
	8a-f	octo	Maryland Baltin	nore	Towson	1				
	ith to	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What Cou	ntry?
	ath v 23e	ā	12 Wilfred Ct.				204		U.S.A.	
	r de	Funerai	11. Marital Status	<ol><li>Was Deceden Armed Forces</li></ol>	?	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? ın, Mexican, Pı	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White	
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 show the Madical Examinations De notified at	Y	1 Never Married 2 Married	1 Tes 2 T	1	1 ☐ Yes 25 No	Specify:		Specify: Talh	ite
21215-0036	ural';	d by	3 Widowed 4 Divorced	Year or Dates:					VVII	
5	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occupa kind of work done of	during most of	working	16b. Kind of Business/Ir	ndustry
2	ithin ne.	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired	,		M- 1:1	
C	filed w Hygier other ti	Ö		4 years	S Ke	egistered			Medical	
pu	buld be filed withing Mental Hygiene.  arked other thar atic evant, Thy Mentice of the than the strice of the thing Mentice of the thin	Be	17. Father's Name (First, Middle, Last)				18. Mothers I	Name (First, Middle, A	Maiden Sumame)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygtene. itam 27 Is marked other than "natural", or ftams 23e or 28e-f show other traumatic evant. If the M. dical Exercitors in 181 be in Affiliad at	ပ္		orman				Lillian 3		
lar	and and Is m		19a. Informant's Name/Relationship (7			-			City or Town, State, Zi	o Code)
7	and ealth m 27		Clewell Howell, J	r. (hus			t. Tows	son, Maryla		
ore	ges 1 If of H If ita		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	e)	Date	20c. Location - City or T	own, State
Ē	Pag nent ant:		' 4 ☐ Donation 5 ☐ Other (Specify		Druid Ric			5-10 <b>-</b> 04	Pikesville,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other tra once.		21. Signature of Funeral Service Licen	S88	M-22	Name and Address	ss of Facility	d Funoral	Home, Inc.	
m	898 9		Llevry h F.	erran	-	6500 Yor	k Road	Baltimore	Maryland	21212
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause	ed the death. Do not ent	er the mode of dyin	g, such as card	diac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final	1		INCOR				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a	s a consequence of):	mod				YEOULS
	Examiner				7					
L		er	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a consequence of):					
	uted d ansit	m	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•						
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687	The law requires that the death certificate be executed tae been signed by the attending physician and page 2 should be detached for use as the burial-transit	edic		u						
Box	eath certific attending p I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of deliv	erv
ă	atter atter	Physician/M	in the past 12-months?			]Ectopic pregnancy ] Other <i>(specify)</i>			Month	Day Year
o.	that the de ed by the detached	ıysi	1 □ Yes 2 XNo 9 □ Unknown	9□ Unknown						
Ω.	that the od by detac		Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
Records,	uires tha signed I Id be det	Completed by						1 <b>X</b> Ye	s 2 □ No 3 □ Prol	bably 4 Unknown
Ö	v requir been si should	ete			_			24a. Was ar	245 Wassaut	
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=								1 Yes 2	No 1 ☐ Yes	2 🗌 No
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	ar	Death (Check only orle	-	1
of	Phys this al dir	은	1 Yes 2 No 27. Manner of Death	1 🗀 Inpat		I 3LI DOA	4   Nursin	g Home 5 Reside		mudipice
L	ding I. After funer	ion	Matural 5 ☐ Pending	28a. Date of In (Month, D	ay Year) 28b. Time of Injury	Work	Yes 2 No	28d. Describe ho	w injury occurred	
Sic	Attending ir death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		-i A. b 6		162 2 140	29f Leasting (St	root and Number of Du-	-/ D
Division	or A after Dirac in by	Certification:	4 Homicide determined		njury - At home, farm, str etc. <i>(Specify)</i>	eet, ractory, office		City or Town	reet and Number or Run , State)	ar Moute Ivamber,
	urs a		00- 0-44							
	Hos 14 ho Fund tely f	edical		iner: On the basis	t of my knowledge, death of examination and/or in-					
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifier	and manner s	raidu.	29c. License	number	20	9d. Date signed (Month,	Day, Year)
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Į,	2		- Aux	U M	(A)	D>	0 00	3 1	1114 20	7
	1,2		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print (1006	20 8	T- Nottice	1AY 5 a nome up	2/200
			31 Dato-filed (Month Day Year)	VVU)	traria Signatura	· Crava	ں س	1001		
	Sta Registi		31. Date filed (Mooth Day Year)	SZ. HBGIS	trar's Signature	arks				

			For State Registrar		aryland / Dep		nt of H	lealth and l	Mental Hy	giene Reg. No.	-	148	30
	Physicia /Medic	ın	Decedent's Name (First, Middle, La  JUDIT			JA	FFEE	<u> </u>	2. Date of De Month MAY	Day 3,			P M
	Examin		4a. Facility Name (If not institution, gi FUTURE CARE CH			4b. City,	Town, o	or Location of Deat REISTE		4c.	County of Dea	th TIMORE	
F	uneral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday	) If Unde Months	r 1 Year Days	If Under 24 Hrs Hours Min.	9 Date of Ric	rth av, Year)	Q Bis	thplace (State or	Foreign
D	irector		Usual Residence of Decedent	1□M 2□F	68 Yrs.		Cuyo		NOV.23	,1935	5	MAS	SS.
e Marylar	Sa-f ehow	ctor	MD BAL	TIMORE	10c. City, Town or L	STERS	NOT	N				10d. Inside City	
with th	a or 28 be no	Funeral Director	10e. Street and Number	OUN DOAD		10f. Zij	p Code	21136		10g. Citi	zen of What Co	untry? U.S.A.	
death	ns 23 must	era	12020 REISTERST	12. Was Decedent	Ever in U.S. 13.	. Was Dece	edent of h	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No	0-	14. Race - Am	encan Indian,	•
<b>5-0036</b> 72 hours after death with the Maryland	in or near an every an experience of search and treat the red life of experience of other traumatic event, the Medical Exactive must be red lifed at	by	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 🐧  If Yes, Give Year or Dates:	No	If Yes, spe			to Hican, etc.)		Black, Whi	WHITE	
T 6	nn "natur Medical	Completed	15. Decedent's E (Specify only highest gi	ducation a de completed)	(Giv	edent's Usu e kind of wo DO NOT u	ork done	during most of wo	rking		nd of Business	/industry	
	t, the	Con		2		ISEWIF	E	10 14 14 14 14	(F)		HOME		
/lan	arked oth	To Be	17. Father's Name (First, Middle, Las	t)	LIS			ANYAR			(	UNKNOWN)	)
	item 27 is my r other trauma		19a. Informant's Name/Relationship BETSY OFFERMANN					DRIVE -	BALTIMO				
Baltimore,	ent of re nt: If item ry or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 1 ☐ Donation 5 ☐ Other (Special Content of the Content o		20b. Place of Disp cemetery, cri	ematory or	other pla	<sup>∞</sup> CORP. 5/5	/2004	20c. Lo	cation - City or TOWSON		
Baltimo	Important: If eny injury or once.		21. Signature of Funeral Service Lio			22. Name a	nd Addre		OL LEVI		& BROS	., INC.	208
Exa	ysician Medical aminer	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a Due to (or as				ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Betw Onset and D	ween Death
). Box 68760, e death certificate be execut	he attending physician and ned for use as the burial-transit	Physiclan/Medical Exar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 IMo	d23c. If yes, outcome	2 Fetal death 3	□Ectopic p		ry			23d. Date of de Month		'ear
Records, P.O.	igned by the a be detached t	by Phy	9 ☐ Unknown  Part II. Other significant conditions	1	out not resulting in the	underlying	cause gr	ven in Part I.				o the cause of de	
ecord aw requir	plnous	Completed	134/20	tension					24a. Was	an .		utopsy findings a	
<u>a</u>	page 2	Com							perfe 1 ☐ Yes	ormed2~	death?	s 2□ No	
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Of \	this c	10	1 ☐ Yes 2 ☑ No 27. Manney of Death	Hospital: 1 Inpat	ent 2 ER/Outpatie		UA		Home 5 ☐ Res			ecify)	
C gill	After funer	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on be 390 Place of In	ay Year) Injury	М		Yes 2□No	28f. Location	(Street an	d Number or A	ural Route Numb	ber,
Div	within 24 hours after deat To the Funeral Director: completely filled in by the	Il Certi	4 Homicide determine	building, e	tc. (Specify)				City or To			s stated	
e Hos	e Fun letely	ledical			of examination and/or								)
To the	To th	Me	29b. Signature and title of certified	U 1	NA	29		se number		29d. Dat	te signed (Mon	th, Day, Year)	
	17		30. Name and address of person wh	completed cause of	death (Item 23a) (Type	e, Print)	18	38 60	eeno -	Tres	re 1	21 2	12
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	_							

DHMH 17 Rev 1/2001

ORIGINAL ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year ELIZABETH KIRK MARIA 2:15 A.M MAY 6, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPICE OF BALTIMORE-GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M **X** X F 93 195-07-2928 Yrs. Director 07-02-1910 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or iteme 23a or 28e-f show treumatic event, the Madical Examinar must be notified at MD. Directo BALTIMORE LUTHERVILLE 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1608 TREBOR COURT 21093 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Ā 1 ☐ Yes XIX No Specify: 3€Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: if item 27 is marked other then nat any injury or other treumatic event, the Mades once. 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) CANDY COMPANY SECRETARY / BOOK KEEPER YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **GEORGE** Ε. NICKOL MARY KRIGER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) M. KRISTINE KIRK 13 NIGHINGALE WAY, LUTHERVILLE, MARYLAND, 21093 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 05-08-2004 ST.JOSEPH'S CEMETERY FULLERTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive cardio myopathy Immediate Cause (Final Physician ears disease or condition resulting in death) /Medical Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 2 No. 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? of Vital 1 Yes 2) No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) H3 Vice 1 ☐ Yes 2 🔀 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division or Attanding 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier To the Hosp within 24 ho To the Func completely f (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAY 6, 2004 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Balto Md Z(204 6Bm( Riley 33. Registrar's Signatur State Registrar

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	/Medi Examir		4a. Facility Name (If r		-	rm <i>ber)</i>		4b. City, To	own, or		f Death			ounty of Deat	h
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	Director		Usual Residence of D	ecedent	X	102						JUNE 27	', ° 19	<del>                                      </del>	RUSSIA
	Marylan f show	ō	10a. State	10b. County N/A		10c. City	Town or Lo	cation IMORE							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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936	72 hours after death with the Maryland natural', or Itama 23a or 28a-1 show afted Examinst coust be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 🔀 Widowed 4	_	Armed Fo	2X No ve		Vas Decedei f Yes, specify I ☐ Yes 2	/ Cuban	panic Orig , Mexican, Specify:	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		Race - Ame Black, White pecify:	
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Baltimore,	Pag nent ant: I		'4 □ Donavion	Other (Spe	11 //	State OHE	B SHAL	OM ME	MORI	AL 📒	5/5/	2004	REIS	STERSTO	WN, MD
Bal	permit. Pag Department Important: any injury o		MALL	8900 REISTERSTOWN ROAD								LEVINS OAD - P			
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_^	cate be executed physician and the burial-transit	Examin	Cause (Disease or inj that initiated events resulting in death) Las		c	(or as a conseque	ence of):								
38760	ate be e nysiciar he buri	dical			d										
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Division	of or Attending after death. I Director: After d in by the fune	icati	2 Accident	investigat	t be One Blace	of Injury - At hom	no farm stre	M ent factory o		s 2 □ N	-	8f Location /St	root and N	lumbar or Du	al Route Number,
Ω	in the second	Certification:	4 Homicide	determine	buildi	ng, etc. (Specify)	10, 1am, 3m	et, lactory, o	11100		-	City or Town	, State)	rumber or Aur	ar nodie rediiber,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)	Certifying Medical Ex	Physician: To the aminer: On the b and man	best of my knowl asis of examination ner stated.	ledge, death on and/or inv	occurred at testigation, in	the time my opir	, date and nion, death	place, a	nd due to the ca d at the time, da	iuse(s) and ate and pla	d manner as s ace, and due f	stated. to the cause(s)
)	To t To t	Σ	29b. Signature and litt	le of certifier	Lin	2		29c. L	339	143		29	5/3	igned (Month,	Day, Year)
	8		30. Name and addless	- >	1 .	e of death (Item 2	23a) (Type, F	Print)	d-	Jo			10	-/	
	Sta	te	31. Date filed (Month.	Day, Year)	32. F	legistrar's Signatu	Ire / C	Print) Porto	40	4					
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 L 14804 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year MAY 3, **Physician** 2004 KAUFMAN 8:30 A M MOLLIE /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A 3810 GREENWAY 8. Date of Birth (Month, Day Year) MAR. 3, 1908 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number **Funeral** Min. Days Hours Months 1 ☐ M 2 🛛 F 96 Yrs. NY 064-05-9815 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show It a Medical Examiner must be redified at 1 Yes 2 □ No BALTIMORE Director MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 U.S.A. 3810 GREENWAY Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. Specify: þ 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within.
Department of Health and Mantal Hygiene.
Important: If item 27 Is marked other than "n any injury or other traumalic event, Ita Meal once. College (1-4or 5+) Elementary/Secondary (0-12) MOVIE STAR INC. VICE PRESIDENT & TREASURER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DORA FINK MEYER ELIAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3810 GREENWAY - BALTIMORE, MD 21218 MICHAEL KAUFMAN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MONTEFIORE CEMETERY 5/5/2004 ST. ALBANS, NY 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Penghal Vancila Disaso **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown been signed by is should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 1 Yes 2 No Attending Physician: After this certification funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatere and title of certifier 5/3/4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rey tenton IV A-Winks 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

	n with the Marylar 3a or 28a-f show	E DI	10e. Street and Number	sell Ave	nue #511			10f. Zip Code	, 20877			_	en of What Cou JSA	intry :		
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			30. Name and address	s of person who co	ompleted cause of de	Path (Item 2:	1	Print)	Gaith	ribuci	Ma	0.20	878	7007		
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State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician JOSEPH** LODEN MAY 2004 2:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Saint Joseph Medical Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Maryland 215-18-3490 86 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or Itema 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1X Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Croydon Road 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1942-46 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, the Mexany injury or other traumatic event, the Mexan Elementary/Secondary (0-12) College (1-4or 5+) 4 years Executive Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Loden Ruth Morse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Loden (wife) 104 Croydon Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens 5-5-04 Timonium, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ANOXIC ENCEPHALOPATHY /Medical Due to (or as a consequence of): **Examiner** CARDIOPULMONARY ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit ASPIRATION PNEUMONIA Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown pieted been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No Com 2 No 1 🗌 Yes 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30263 Đ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS
31. Date filed (Month 76-21 OSLE 32. Registrar's Signature , Day, Year) OSLER DRIVE TOWSON MARYLAND 21204 State MAY 07 2004 Registrar Docker

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	To the Hospital or Attend

	1 - State Registrar  1. Decedent's Nam	ne (First, Middle, Last,			Department of Certificate o		Reg.	thou the tip 1	3. Time of Deat
cian lical iner		M. Lacoste			4b. City-Town	or Location of Death	05 C	Day Year 25 200 4c County of Dea	45:14 p.
ıl e	5. Social Security	In Sau	are He	OS DIT	al Ko	SECULE  If Under 24 Hrs.  S Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 12,	Bathy 9. Bir	nore thplace (State or Fore oughty). uisiana
r	433-26- Usual Residence of 10a. State	0 17 1	<sup>™</sup> x  95		wn or Location		Feb. 12,	1909 LO	10d. Inside City Lir
Director	Md.	Baltimo	re		Kingsville		100	Citizen of What C	1 Tes 2 2
rai Dir		Volbert Wa	у			21087	U	nited St	ates
To Be Completed by Funeral Director	11. Marital Status 1 □ Never Man 3 □ Widowed	ried 2 Married 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spe iban, Mexican, Puerto o <i>Specity:</i>	ecify Yes or No- Rican, etc.)	14. Race - Ami Black, Whi Specify:	
Completed	(Spec	15. Decedent's Edu cify only highest grad ondary (0-12)		+)		upation e during most of worki red)	ing 16t	. Kind of Business	•
Be Cor	12 year	(First, Middle, Last)		h	omemaker	18. Mother's Name	(First, Middle, Mai	own hor	me
ToB		Villiam Re		101	h Mailine Address (Char		Mohan	7 T O	T. O. f.
		Lacoste,			b. Mailing Address (Stre 12419 Wo1be				
		sposition  Cremation 3 F 5 Other (Specify)		cemete	of Disposition (Name of ery, crematory or other p Air Mem. Gdr.	lace)		Location - City or	
XIIVE	21. Signature of F	uneral Service Licens the disease, or complete	00	the death. Do	610 W.	ress of Facility lek Funeral MacPhail R	oad, Bel		21014
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State of Maryland / Department of Health and Mental Hygien ()

			1- State of Maryland / Department of Health and Me RegistraMFND TIFM #788 PER FH C831 5/11/04 Pertificate of Death			14808
	Physici	200	1. Decedent's Name (First, Middle, Last)	Reg. I 2. Date of Death Month		3. Time of Death
	Physici /Medi	cal	HENRIETTA J. LASTNER	May (	0 2004	2:15 AM
	Examir	ier	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  North Anudel Hospital  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	P	Anne Are	Inde/ Diace (State or Foreign
	Funeral Director		215-05-8365  1 M 2 X F 87 86 Yrs. Months Days Hours Min.	8. Date of Birth 1— (Month, Day, 1-e EC 31, 1	917 MAR	orace (State of Foreign MYLAND
	and		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location		1	I0d. Inside City Limits
	Marylan ••f show	to	MARYLAND ANNE ARUNDEL GLEN BURNIE			1 □ Yes 2 🛣 No
中本	ith the Mi or 28e-f	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	ntry?
	ier death w Items 23s	eral	102 CRAIN HIGHWAY N. APT. 868 21061  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec		IITED STAT	
Henrie	a a	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 No If Yes, Specify Cuban, Mexican, Puerto R  1 Yes, Sive Year or Dates:	ican, etc.)	14. Race - Americ Black, White, Specify: WH	
	72 hours "natural",	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/In	dustry
nar Her 21215-0036	e filed within all Hygiene. I other than "I vent, I'm Ment	Completed	Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER		OWN HOME	
land 2121!	be filed that Hygie of other seent, I	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name (			
Last	2 should be and Mental Is marked o	2	WADE TURNER  MARY HOF			
	and 2 st ealth and n 27 ls r		19a. Informant's Name/Relationship (Type, Print)  EDWARD C. LASTNER - SON  19b. Mailing Address (Street and Number or Rural) 6797 ATHOL AVENUE ELK	RIDGE, MA		1075
altimore,	Pages 1 and 2 lent of Health int: If item 27 I		20a. Method of Disposition  1 Deural 2 Cremation 3 Removal from State  4 Department of Disposition (Name of cemetery, crematory or other place)  MAY 10  MEADOWRIDGE MEM. PK.	,	Location - City or To	
altin	permit. Pages Department of t Important: If ite any injury or of		_ ( / / / /		KRIDGE, M	ARILAND 1061
ä	De di Li		21. Signature of Formal Serve Licensee  KIRKLEY = RUDDICK 421 CRAIN HIGHWAY S.	E. GLENEB	URNIE, MA	RYLAND
	Physician		23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Tyo covd ad Tweeter and average are cardiac or shock or	respiratory arrest,		Approximate Interval Between Onset and Death
h A	/Medical Examiner		Technology Canal Day and Day			
W.	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)  The conditions of the co			
ó	cate be executed physician and the buriat-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760	cate be physicia the bur	dlcal	d			
9	as a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	ary.
Division of Vital Records, P.O. Box	Physician: The law requires that the death certifin this certificate has been signed by the attending trail director, page 2 should be detached for use as	by Physician/Me	in the past 12 months?  1  Yes 2 No 9  Unknown  1  Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)		Month	Day Year
ds, P	v requires that the death been signed by the atte should be detached for	d by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the	
oco	se law requ has been ge 2 should	Completed		24a. Was an	24b. Were auto	psy findings available inpletion of cause of
<u> </u>	: The cate ha	Сош		autopsy performed? 1 ☐ Yes 2 ☑	death?	. /
Vits	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?  1   Yes   2   No			
οſ	ding Phys n. After this funeral di	n: To	27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	d. Describe how in	6 ☐Other (Specif) jury occurred	′)
sior	Attending ir death. ector: Alter by the funer	catio	2 Accident investigation M 1 Yes 2 No			
Divi	al or At s after c at Direct ad in by	Certification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street: City or Town, Sta	and Number or Rura ite)	l Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the caused at the time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier  Aleonary C. Wills TAT 17, D. 29c. License number D41365	29d. C	Pate signed (Month,	2004
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TENGE E, Wicks M. M. 30) Was pital Drive, Gen	n Burni	e, MD,	21061
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** James Joseph Loughrey may 2004 /Medical 4c. County of Deeth Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harton Be ea Lth lariner 8. Date of Birth (Month, Dey, Year, NOV. 22, 1 6. Sex 1 → M 2 □ F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min. 152-01-9557 88 New York Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "neturel", or Items 23a 410 East McPhail Road 21014 USA death 1 Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "neturel" only injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 287 Marned 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Production Manager Mattress Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be O'Kane Edward (nmn) Loughrey Mary Ann 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbará Shannon //Daughter P.O. Box 48, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 7 Remi 5 Other (Specify) 4 Donation Hilltop Service Corp. 5-6-04 Towson, Maryland 21. Signature 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 23a/Part. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line inventigate Cause (Final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** week neumunia /Medical resulting in death) Due to (or as a consequence of): **Examiner** (embrouscular Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transil Due to (or as a consequence of): signed by the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 Tyes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 20 No Other: Medical Certification: To 1 ☐ Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🖺 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide To the Hospital 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ろくのナナ 0 Avenue

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 2001 LLBIN 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** may 14:00 PM Dorothy Lee 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltimore Sinai Baltimore Kospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number Funeral Hours 1 □ M 2 🛛 F 212-20-7799 84 Director Aug 16, 1919 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ahow r than "natural", or Items 23a or 28e-f ahov the Medical Examiner must be notified at MDBaltimore 1 Yes 2 No Director 10e Street and Number 10f. Zin Code 10g, Citizen of What Country? 4800 Seton Drive 21215 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: black ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Importent: If tiem 27 ie marked other than "in any injury or other traumatic entert than "in once. Coflege (1-4or 5+) Elementary/Secondary (0-12) nurses aide health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Miller Marie Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Desiree Hudson/niece 1105 E. 43rd Street Baltimore, MD 21239 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 ☐ Other (Specify) 21. Signalure of Euneral S. rvice Rolla Ld State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cancer Lung years /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) physician at s the burial-t P.O. Box 68760 by Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2/2 No 1 ☐ Yes 2 📉 No 1 Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

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completely filled i To the Hospitel 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number death (Item 23a) (Type, Print) Mospital of Baltimore arland Mariya -.
31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAY 0 7 2004

Dorothy

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State of Maryland / Department of Health and Mental Hygiene 2001Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ELLA, MORTON 2004 9:05 AM MAY /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OF MARYLAND BALTIMORE UNIVERSITY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
2 - 5 - 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Director 216-34-6136 VA Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No Director CHARLOTTE COURT HOUSE CHARLOTTE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23923 USA 567 SAWMILL ROAD death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Bleck. White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ğ Specify: 3 X Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Peges 1 and 2 should be filed within ment of Health and Mental Hygiene. ent: If item 27 is marked other than ury or other traumatic event, than wy or other traumatic event, than we 8 IRONING CLOTHING FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES TERRY ESTHER ANDERSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GWENDOLYN MEGGINSON/DAUGHTER 522 LUCIA AVE. BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Importent: If any injury or QDCE. ST. LOUIS BAPTIST CEM. 5-10-04 CHARLOTTE C.H., VA 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. ames 1701-31 LAURENS ST. BALTIMORE, MARYLAND 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL disease or condition resulting in death) INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Exist uncompriging Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physiclan/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) o. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISEASE ON HEMODIALYSIS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an PERIPHERAL VASULLAR DISEASE page 2 certificate DIABETES MELLITUS 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဂ္ 2 ER/Outpatient 3 DOA this 27. Manner of Death ate of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: / I in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Valan, MD AUH17643515140 May, 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Baltimore, Maryland 22 5 Green Snarmeel Wasan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 0 7 2004

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Jean C. Miller MAY 4. 2004 2:12  $\Box$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 1 ☐ M 2 💢 F 216-26-7613 Yrs. 85 February 17,1919 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at Baltimore 3 8 1 Towson Maryland 1 ☐ Yes 2 X No Funeral Direct with the 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 800 Southerly Rd. 21286 United States hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Art teacher education other Alth and Mental Hw 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carrie L. Meyer John N. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 i 102 W. Pennsylvania Ave., Suite 600 Towson, MD 21204 Charles F. Stein, III/pers. rep. Baltimore, other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of He
Importent: If iten
eny injury or oth 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 10, 2004 ¹ 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician UPPER GASTROINTESTINAL BLEET /Medical Due to (or as a consequence of): **Examiner** CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Due to (or as a consequence of): buriai-t Box 68760, attending physician Physician/Medicai the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. the a 9 Unknown 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown HEPATIC ENCEPHALOPATHY Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has e 2 autopsy page 2 X No certificate 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 🛣 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 10 1 Tes 2 this After the funeral 27. Manner of Deall 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) I in by I 4 Homicide within 24 hours a To the Funerel D filled 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai vietelar 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) igned (Month, Day, Year) Tot 29b. Signature and title of certifie D 24034 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso 31. Date filed (Month, Day, Year) 76 01 OSLER 32. Registrar's Signature TOWSON MARYLAND 21204 State 0001 Registrar MAY 07 2004

# unpend itale 38,77,28 of Print in Black Indelibre Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MAY 2004ª Morales 10:45P. <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 601 N.Caroline Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X**M 2□ F Director 218-84-4290 32 August 15,1971 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location f show 10d. Inside City Limits traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director MD Harford Belair 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1335 St. Francis Road 21014 **USA** 238 death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Land Surveyor Development 12 years othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be f nent of Health and Mental I int: If itam 27 Is marked o Doris Dudzinski Maurice Morales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karin Morales 1335 St. Francis Road, Belair, Md. 21014 wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery May 8,2004 Dundalk, MD. `4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. non 7110 Sollers Point Road, Dundlak, Md. 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Heroin Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the ģ signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No cate has by page 2 s certificate 1 Yes 2 🗆 No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{MOther} \( \text{(Specify)} \) SCENE Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA P 1 XYes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 ₩No death. investigation 2 Accident 10:30 p unknown Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ก 24 hou. \*he Funeral D 601 N. Caroline St., Baltimore, MD restroom 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) his. O.C.M.E. MAY 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI M. D 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 20014816 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** April 22, 8:00 AM M 2004 Michael S. Markides /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 717 Maiden Choice Lane #302 Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1924 9. Birthplace (State or Foreign Country)
Greece 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 79 226-62-7753 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28a-1 ehow any injury or other traumatic event. It is Moulcal Examiner man be notified an once. MD 1 ☐ Yes 2X No Baltimore Catonsville Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 717 Maiden Choice Lane #302 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Specify: white 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sophocles Markides ၉ Maria S. Attalides 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Markides/nephew 2 Broadridge Lane Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 ☐ Other (Specify) 21. Signatur of Fun vice Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Sa Stric Cancer month /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): been signed by the attending physicien should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Matural 5 Pending To the noop after death.

You the Funeral Director: Alt 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel t 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 7009 address of person who completed cause of death (Item 23a) (Type, Print) Choice Lane Baltimore MD 21228 Maide 111

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Year)

			1 - For State Registrar	State of Marylan		rtment of I			gienez 0 (	1481	5
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	, -	- Jr.			2. Date of Dea Month	Day 1 20	, , , ,	ath M
	Examir	ner	4a. Facility Name (If not institution, give's Battimore VA M	ledical Cev	nter	Balt	or Location of Deat		4c. County o	VA	
	Funeral Director								y. Yeard 6	9. Birthplace (State or For	reign
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. County	10c. Cit	y, Town or Loc	Baltimo.	re			10d. Inside City Lin	
	with the 3e or 28a	i Direc	10e. Street and Number	St. Apt.	103	10f. Zip Code	71223		10g. Citizen of Wi	hat Country?	
920	urs after death al', or Items 23 Examinar mun	by Funeral Directo	11. Marital Status	2. Was Decedent Ever in U. Amed Forces? 1 ™Yes 2 ☐ No If Yes, Give Year or Dates:		/as Decedent of Nas Pes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race Black Specify:	- American Indian, White, etc.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other treumatic event, the Medical Evaninat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give I	ent's Usual Occup kind of work done O NOT use retire	during most of world)	rking	16b. Kind of Bus	iness/Industry Vide Insportation	J
Maryland	2 should be filled with and Mental Hygiene. is marked other then sumatic event, It an	To Be (	17. Father's Name (First, Middle, Last) Blangie Par	Ker			18. Mother's Nar Eliza	ne (First, Middle, beth Sa	Maiden Sumame	, /	e e
Baltimore, Mar	9 = 5 P		19a. Informant's Namelationship (Type Robbin ParKer 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	Sister  20b. P	8604	- Gray	and Number or Ru FOX K	Date	or, City or Town, S 202 Ran 20c. Location - C DWINGS	dallstown, 1	23 UD.
Balti	permit. Pages Department of Importent: If It eny injury or o		21. Signature of Funeral Service License			Name and Addre	ess of Facility A	For Chav	SECHMA Baltiman	Marylan 3	1229
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as aconsequ	can	r the mode of dyi	ng, such as cardiad	or respiratory an	rest,	Approximate Interval Between Onset and Death	1
8760,	sate be executed obysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)							
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnance Other (specify)	у		23d. Date Monti	,	
	w requires that been signed I should be det	by	Part II. Other significant conditions cond	tributing to death but not rest	alting in the un	derlying cause giv	en in Part I.	23e. Did to		oute to the cause of death?  B Probably 4 Unknown	
of Vital Records,	The law relate has bee page 2 sho	Completed	COVORANY OU	tery dis	eas(	2		24a. Was a autop: perfor	sy pri roed? de	ere autopsy findings availa or to completion of cause ath? ☐ Yes 2 ☐ No	able of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatient	35 DOA Ott		th (Check only or	ne)		
ion of	- E	ition; To	27. Manner of Death   Natural 5   Pending 2   Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injut	4 🗆 Nursing H		ence 6 Other		
Division	el or Attendi s after death. I Director: A id in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	edicai C	29a. Certifier 12 Certifying Physic (Check only one) 2 Medicel Exemin	ician: To the best of my knorer: On the basis of examinal and manner stated.	wledge, death tion and/or inve	occurred at the tirestigation, in my c	me, date and place ppinion, death occu	, and due to the c rred at the time, o	ause(s) and manr late and place, an	ner as stated. d due to the cause(s)	
)	within Comp	Me	29b. Signature and title of certifier	20 non	1	29c. Licens Au4				(Month, Day, Year) 1 2004	
	1		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, F	hmore	76435 VA Med	Ical	Cente	V	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 7 2004	32. Registrar's Signal		ااور					

Blangie R. Parteir

			1 - For State Registrar	State of Marylar		rtment of F			ien <b>e</b> () () (4	14816	
	Physici /Medio		Decedent's Name (First, Middle, Last)	Toni rae	Riley			2. Date of Death	Day Yea		
	Examir Funeral Director		5. Social Security Number 6. Sex	TAGE HOS OF	last birthday) 0 Yrs.	4b. City, Town, o  ROSE  If Under 1 Year  Months Days	r Location of Dea	8. Date of Birth (Month, Day,	4c. County of Do Balt 9. E Year) 9. E 0, 2004 Ma	Birthplace (State or Foreign Country)	
	Maryland f ehow	ior	Usual Residence of Decedent  10a. State 10b. County  MD Baltim		ty, Town or Lo		Essex			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	death with the Maryland ms 23a or 28a-f ehow	i Director	10e. Street and Number 41 Seaford Av			10f. Zip Code	21221	10	Og. Citizen of What	Country?	
_	be filed within 72 hours after death with the Marylar Hygiene.  do Hygiene.  do ther than "natural", or itams 23a or 28a-f show event, the Medical Examine must be publified at	by Funerai		2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If			Specify Yes or No- to Rican, etc.)			
21213-0038	i within 72 hours after liene. r than "natural", or ita the Medical Exentina	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Deced (Give I life. D	ent's Usual Occup kind of work done of OO NOT use retired	ation during most of wo	orking	16b. Kind of Busines	,	
yland	2 should be filed and Mental Hygid Is marked other raumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Jason Lee Ril	-			Kri	me (First, Middle, M SS Lee K	Maiden Surname) Kozlowsk	i	
re, mar	Health Health tem 27 other t		19a. Informant's Name/Relationship (Typ.  Kriss Lee Kozlo  20a. Method of Disposition	wski/mother	r 41 S		Ave. B			21	
Saltimor	permit. Pages Department of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeraf Service License	Ba	ayview	Cremato	ory 5/	5,01	Baltimor FuneralH	Te MD  IomeofEssex	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Extreme Due to (or as a conseq	Pre 1			e. Baltir		21221 Approximate Interval Between Onset and Death	
,0070	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq							
.O. DOX	w requires that the death certifics been signed by the attending ph should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	tc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	l déath 3⊡l	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year	
י ה ה	equires that the signed by loud be detach	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use co							contribute to the cause of death?	
ימו חברו		e Completed	25. Was case referred to medical						ed? prior to death? □ No 1 2 Ye		
	ng Phys fler this ineral di	To B	examiner?	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of fnjury	28c. Injury Work	er: 4 ☐ Nursing H	ath Check only one flowe 5 Residen 28d. Describe how	ice 6 Other (Sp	ecify)	
SIA	To the Hospital or Attends within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of fnjury - At ho building, etc. (Specify	y) 		*****	City or Town,	State)	Rural Route Number,	
	the Hosp hin 24 hor the Fune mpletely fi	Medical	one) 2 Medicar Examin	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inve	estigation, in my op	pinion, death occu	irred at the time, dat	e and place, and du	e to the cause(s)	
	Z × Z × Z		29b. Signature and tiple of certifier  JAI  30. Name and address of person who con	LALL MB	220\/T	29c. License	5 000		1. Date signed (Mor	ип, Day, Year)	
	Sta	te	31. Date filed (Month, Day, Year)	Dailall 90  82. Registrar's Signa	006 Fre	inklin S	quale D	rive Bal	timore, A	ID 21237	
	Registra		MAT 0 7 2004	Derma	19 A	med.					

Yary Girl KOZIOWSKI

			For State Registrar	State of Ma	ryland / [	Depa Ce	artment of H	ealth a	and M		giene 2 (	004	14817
	Physici /Medic	4	Decedent's Name (First, Middle, Last)	Enola 1	L. Rob	ert	īs			2. Date of De. Month		Year O 4	3. Time of Death 6:15p M
	Examin Funeral		<ol><li>Social Security Number 6. Sex</li></ol>	hesapeal	(In yrs. last bir	thday)	4b. City, Town, or  Arnol  If Under 1 Year  Months Days	_		8. Date of Birt (Month, Da	4c. Coun Anne	ty of Deeth	1
	Director		Usual Residence of Decedent	M 2 <b>∑</b> F	- 00	Yrs.		Hours	Will 1.	Jan.2	1924	Wes	tVirginia
	e Marylan e-1 show iilied al	ctor	MD Baltimo	re	10c. City, Tow		iddle Ri	ver					10d. Inside City Limits 1 ☐ Yes 2√2 No
	3a or 28	al Director	1324 Fuselage	Ave.			10f. Zip Code 2122	0			10g. Citizen o $USA$	f What Cou	untry?
336	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-1 show the Madrell Exercites result the mattified at	by Funeral	11. Marital Status  1 Never Married 212 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🔯 No	spanic Or n, Mexical Specify:	n, Puerto	ecify Yes or No Rican, etc.)	ВІ	ace - Ameri lack, White	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygliene. Id other then "natural", or items 23a or 28e-1 show event, the Madical Extroduct count be natified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		<b>→</b> )	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired,	lurina mos	st of work	ing	16b. Kind of	Business/Ir	ndustry
land 2	buld be fitted Mental Hygid arked other atto event, Ill	To Be C	17. Father's Name (First, Middle, Last)  Jesse A. Mitc	hell						e (First, Middle,	Maiden Suma		
	nd 2 shoulth and 27 Is m		19a. Informant's Name/Relationship (Type Eugene Roberts	•			ng Address (Street a				•		p Code)
timore,	Pages 1 aunent of Healunt: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ri 1 ☐ Donation 5 ☐ Other (Specify)		20b. Place of cemeter	Dispo	osition (Name of matory or other place ValLEY			3/04	20c. Location	n - City or T	
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service License		. Oli	22	2. Name and Addres		Co	_			meofEssex
×	Physician /Medical Examiner		23a. Part 1. Enter the disease, or compleshock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	tod :	the death of e.		er the mode of dying	g, such as	cardiac	or respiratory ar	rrest,	PID . Z	Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence								
O. Box 6	The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Note:	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)					Date of deliver	very Day Year
rds, P.	quires that n signed b uld be deta	by	Part II. Dther significant conditions con	tributing to death bu	t not resulting in	n the u	nderlying cause give	en in Part I			obacco use co ∕es 2□No	ntribute to	the cause of death?
I Record	The law requir sate has been si page 2 should	Completed									an 24b osy rmed? 2.77 No	o. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available ompletion of cause of
Vital	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	ospital:			Othe	er Harte		(Check only o			
Division of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	1-1	1 Yes 2 No ''  27. Manner eath 1 Unitural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injur (Month, Day		Time o njury	f 28c. Injury Work	The state of		me 5 🗌 Resid 28d. Describe I			ify)
Divis	tal or Attendi rs after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	ırm, stı	reet, factory, office			28f. Location (5 City or Tox		nber or Rur	ral Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier Check only one) 4 Certifying Physical Examination (Check only one)	ician: To the best of ler: On the basis of and manner sta	examination an	e, deat id/or in	h occurred at the tim vestigation, in my op	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) and r date and place	manner as s e, and due t	stated. to the cause(s)
	To the within 2 To the comple	W	29b. Signature and title of certifier	1	2	_/	Mr) <sup>29c.</sup> License	5	07	25	29d. Date sign	ned (Month,	2004
	N	(	30 Name and address of person who co	gor 860	11 Vete	(Type,	ns Hug	M.	ller	sville	, M.	0	21108
76	Sta Registi		31. Date filed (Month, Day, Year)	Sene Service	r's Signature	de	melal						

within 24 hours e To the Funerel (

State Registrar

Medical

29b. Signature and title of certifier

29a. Certifier

Milan Signature 32 Registrar

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOONE

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

APRIL 29, 2004

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 29 Day Oliver John Smith 2004 April /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel P.G. Honder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Feb. 19, 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1<del>√</del>M 2□ F 578-36-3247 71 Director Washington. Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at DC Washington Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or itams 23a or; any injury or other traumatic event. In a Medical Ferror. 1804 Benning Road N.E. 20002 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: 1955 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Black XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) Painter Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Smith Mary Convers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adeline Bolden -Sister 1920 Ore on Ave. Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Harmony Mem. Park 5/5/2004 Landover, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licenses 3821 14th ST, N.W. Wash, DC 20011 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final Physician CARDIAC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ISCHEMIC HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed ONGESTIVE HEART and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) Ö the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 DOA = DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funaral Di completely fitled in 29a. Certifier (s) and manner as stated. Medical 2 Medical Examiner: On the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter-stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ND 32444 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) O. DARKO GODWIN 110 IRVING ST, NW MASHINGTON DC 20010 MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State South Registrar

				State of Maryland / Department of Health and M	Mental Hygie	ne2004	14820
				1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)	Reg.	No.	
	н	Physici	an	1 2000	Date of Death     Month	Day Year	3. Time of Death
		/Media	cal	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	may	5 2004	10:35PM
		Examir	ner	North Arundel Hospital Glen Burnie		Anne A	frondel
		Funeral Director		5. Social Security Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (b) onth, Day, Ye	9. Birth	place (State or Foreign intry)
				Usuel Residence of Decedent  10a. State 10b. County A 10c. City, Town or Location	I IFRCH AC	0,1942 0	PLO
		2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "naturel", or items 23a or 28e-f show reumatic event, it a Medical Evana et must be redified at	tor	MD Anne Arundel Glen Burnie			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
		or 28e	Funeral Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	intry?
		ms 23e	erai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri	
5	36	s after	by Fur	1 Never Married 2 Married 1 Yes 2 No	Pican, etc.)	Black, White	, etc.
mes	5-0036	72 hour naturel	ted b	3 Widowed 4 Divorced Year or Dates: 1960 - 1964  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done)	ing 16b	o. Kind of Business/Ir	ndustry
3	2	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  Elementary/Secondary (0-12)  Elementary/Secondary (0-12)  Elementary/Secondary (0-12)  Elementary/Secondary (0-12)	ang .	Cooling	Loo
17	nd 21	il Hygi other /ent, I	Be Co		e (First, Middle, Maid		tol
2	Maryland	should be filed and Mental Hygie is marked other sumatic event, II	ToE	Robert Earl Tonner Grace		iams	
16	Mar	and 2 should ealth and Mer n 27 is marke her treumatic	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Rur  RAEWYN Tonner - Laughter 6104 Frederick Ave Apt	2 Alacci	ty or To State, Zi	o Code)
JU	ore,	T T T T		20a. Method of Disposition  20b. Place of Disposition (Name of 1) Burial 2 Micromation 3 Removal from State  20b. Place of Disposition (Name of 1) Place of Dispositi	Date 2	cation - City or T	own, State
0	Baltimore,			4 □ Donation 5 □ Other (Specify)  21. Signature Funeral Service Licens 2  22. Name and A sess of Facility	-04 L	MIto. 11	$\nu$
	Ba	permit. Departn Importe any inji		1 1 1 1 1 10 100	Valley D	dr. Jossep,	PA 18434
				23a. Part 1. Energine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or beart failure. List only one cause on each line.  Immediate cause (Final	or respiratory arrest,		Approximate Interval Between Onset and Death
		Physician /Medical		disease of condition resulting in death)  Due to (or as a consequence of):	513		
		Examiner	<u></u>	Sequentially list conditions, if any leading to immediate  b. Due to (or as a consequence of).	らり		
		d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
	8760,	sicien and burial-transit		resulting in death) Last Due to (or as a consequence of):			
	687	ficate by physical distribution of the transfer of the transfe	edical	d.			
	Box 6	leath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliv	ery Day Year
	P.O. E	that the desired by the at	ysic	1 □ Pes 2 □ No 9 □ Unknown 9 □ Unknown		Month	Day 16al
	s, P	res that igned b be deta	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to t	
	cord	w requir been si should	leted		1 ☐ Yes 24a. Was an		
	Re	The lav	Completed		autopsy performed 1 Yes 2	prior to co	opsy findings available ompletion of cause of
	/ita	sicien: Th certificate rector, pag	Be	examiner?	h (Check only one)		1
	of \	Physi this c	7.	Hospital: Tuppatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Ho	ome 5 Residence		(y)
	ion	nding F ith. :: After e funer	ation	27. Manner of De th  1 Natural 5 Pending 2 Accident investigation  28a. Dale of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No		nary occurred	
8	Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Run tate)	al Route Number,
/		spitel hours a merel C		29a. Certifier + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause	a(s) and manner as s	stated.
		the Ho hin 24 the Fu	Medical	(Check only one)  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurrand manner stated.  29b. Signature and title of certifier  29c. License number			ì
		T wit		1 m D + 8006	ma	Date signed (Month,	2004
		9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KOF) BOAITEY, SOI Hospital	D- 1	Glm B	Mu/Hum
	ľ	Sta Registr		31. Date filod (Month, Day, Year)  32. Registrar's Signature  April  Apr	/		

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Juanita lorbin 10.25 AM 3 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Agnes Healthcare Baltimore 5. Social Security Number Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Months Hours 213-62-699 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location r than "natural; or itama 23a or 28a-f show the Mudical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland 10e. Street and Number 10g. Citizen of What Country? death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) state of Maryland other than Elementary/Secondary (0-12) College (1-4or 5+) tacilitata Department of Heath and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Belle 10/61 Pages 1 and 2 should 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justin Womack Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Furgeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PAILURE ACUTE HEPATIC MONTH /Medical Due to (or as a consequence of): **Examiner** CARCINOMA YEARS BREAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a nonsequence of) The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 MUnknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed? certificate 1□ Yes 2⊠ No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 2 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 Suicide within 24 hours after de To tha Funaral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the best of my knowledge. Jean Decurred at the time, date and place, and due to the eausy(s) and it armet as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nicupamadui May 03,2004 M.D. P17600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE, BALTIMORE , MD-21229 MITIKIRI NIRUPAMA 900 CATUN 31. Date filed (Month, Day, Year) 32, Registrar's Signature State 7 2004 Registrar

**ORIGINAL** 

Manita

DHMH 17 Rev 1/200

Registrar

JEANNE

TAYLOR,

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month MA **Physician** EDITH TOPOROVICH 10:31 AM 1 6 7005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins BAYVIEW MEDICAL CONTEX BAITIMURE SAITHURE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** February 12, 1916 219-35-0795 1 ☐ M 2 🖾 F 88 Yrs. Director New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show Examiner must be notified at MD 1 ☐ Yes 2√2 No Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 1918 Midland Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Yes 27 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Year or Dates: "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 years Housewife . Own Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itsm 27 is marked othe any light or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Goehringer Mary Fey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Toporovich Husband 1918 Midland Road, Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Garrison Forest VA. May 11,2004 Owings Mills,MD \*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral/Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part I. Enter the disease for complications that caused the death. Donot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** Prieumonia ASPIRATION 3 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760, attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the f 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-001 30. Name and addr - of person who completed cause of death. Item 23a) (Type, Print) 4940 EASIEN ANT BAITHURE ART ELIZAbeth 31. Date filed (Month, Day, Year)
MAY 0 7 2004 82. Registrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death Month **Physician** Dav Vear Deborah Elaine Thomas 04 /Medical 7:45 AM 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner PERAN RIVERSIDE If Under 24 Hrs. 5. Social Security Number 6 Sex If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Yrs Director 49 219-60-5435 Feb. 18, 1955 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits pamit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28e-f ehor any injury or other traumatic event, the Medical Examinar must be notified at Director 1 X Yes 2 □ No Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 136 Alice Anne Street 21014 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Š Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Secretary Public Education 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifton William Thomas, Sr. Dorothy Mae Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Mac Thomas / Mother 136 Alice Anne St., Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Hilltop Service Corp. 5-6-04 Towson, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Mara 1 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pert1. Enter the diseas a simplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physiclan/Medical Examiner or Attending Physician: The law raquiras that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) signed by the aid be datached for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No δ Completed 24b. Were autopsy findings available prior to completion of cause of death? the performant the no nunther disa 1 Yes 2 00 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Alatural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in I To the Hospital of within 24 hours at To the Funeral D completely filled in 1 PCPCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) MycPhan rd 16 Ulive um 6/ 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State MAY 0 7 2004 Registrar

MICHAEL WILLIAMS unpend item#23a,27,28a-f,Per ME,C831,5/18/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03022 RKD State of Maryland / Department of Health and Mental Hygiene 14826 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mich 281 Williams MAY 3.2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALT IMORE

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. JOHNS HOPKINS HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 M. D. Funeral 1**Ø**M 2□F Months Vrs 220 64 0522 June 16, 1959 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 ie marked other than "neturel", or items 23a or 28a-f shov treumatic event, It e Madical Examiner must be mailled al BA HIMORE 1 Yes 2 No Director MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1820 11.5.A Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plant Chemical Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BERNICE JUNES TRANK Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BAHMIC MD 21213 f Health a BERNICE Charel 1820 Williams Importent: If item, any injury or othe, once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ARbutus Memorial 5/8/04 BAltimore MD. 22. Name and Address of Facility BEHS FuneRAI Home 21. Signature of Funeral Service Licensee Yatucia) Buss 1129 N. CARDINS ST BA HIMURE MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Narcotic and Alcohol Intoxication **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 5 Cther (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2□ No 1 Yes 2 🗆 No 1 XYes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 1X Yes 2 □ No Certification; To To the Hospital or Attending PP within 24 hours after death.
To the Funeral Director: After the sempletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 🗌 Natural 5 Pending 5/3/04 found unknown 1 ☐ Yes 2 X No unknown investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. /Specify)

found at home 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1820 N. Chapel Street, Baltimore, MD 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) Greenberg MD O.C.M.E. MAY 4,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

Tasha Z Greenberg

31. Date filed (Month, Day, Year)

MAY 0 7 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician Month 1 2000 /Medical 2:30p 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner **GENESIS** FUTURECARE NURSING CENTER RANDALLSTOWN BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Months Hours 114 Director NORTH CAROLINA Usuel Residence of Decedent parmit. Pages 1 and 2 should be filled within 72 hours aftar death with the Marylend Dapartment of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantical trust be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. BALTIMORE 1√2 Yes 2 □ No Director RANDALLSTOWN 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 8 BURROAK CT. 21133 USA 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify. Be Completed by Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12--0-NURSING ASSISTANT HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK ALLEN DELLA HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) DONNA WHITE (DAUGHTER) 8 BURROAK CT. RANDALLSTOWN, MARYLAND 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VETERANS 5-5-2004 OWINGS MILLS, MARYLAND 21. Signat re of uneral Service Licens eGUI VERE 22. Name and Address of Facility REDD FUNERAL SERVICE REDD 1721--21 N. MONROE ST. BALTIMORE, MAKYLAND 21217 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Completed by Physician/Medical Examiner The law requires that the daath certificate be axecuted attending physician and for use es tha burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? certificata has b director, page 2 s 1 Yes 2 NO 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: ours after daath.

eral Director: After this certifica fillad in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) edical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 4 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D completely filled Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only To the 29b. Signature and title of certified 29c. License numbe. 29d. Date signed (Month, Day, Year) UUD h 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) aw NERNE 838 9 NEE 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 7 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene $2 \cap \cap \downarrow$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Yeer **Physician** MARY WOLF mai 230AM 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month Day, Year) OCT.11,1908 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F 95 112-22-6742 Director NY Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28s-f show Examiner must be notified at 1 Yes 2 No N/A BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2434 W. BELVEDERE AVENUE 21215 Items 23e U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after t Never Married 2 Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 👿 No WHITE 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME if Health and Mental Hyginitem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL POLACHEK **ESTHER** (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 W. CLIVEDEN ROAD - PIKESVILLE, MD 21208 ED FISHMAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) = 5 Department Important: heny Injury o BALTIMORE HEBREW CEM. 5/5/2004 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Lice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End- Style

Due to (or as a consequence of): Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physicien and I be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 3 DEctopic pregnancy Month Day Year 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 22 No ector. 25. Was case referred to medical 26. Place of Death Check only one 1 Yes 2 No Certification; To Other: 1 Inpatient 2 ER/Outpatient uneral dir 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56508 M.D XIANGRONG 30. Name a address of person who completed cause of death (Item 23a) (Type, Print) Belvede ave 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 07 2004 Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician White 2004 4:45 May АМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7604 Berkshire Road Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ★M 2 □ F Months Days 61 Director 215-40-4633 MD. *J*anuary 27,1943 Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show itam 27 is marked other than "natural", or itams 23a or 28e-f show other traumatic event, the Mical Exp. director rest be notified at Directo MD. Baltimore Dundalk 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7604 Berkshire Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: ğ Specify: 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "ne any njury or other traumatic event, The Mustic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 years 2 years State Trooper First Class State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harold White Helen Wermelskirchen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shena Marie Hill Daughter 311 Tuscarora Trail, Taneytown, MD. 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory May 10,2004 Baltimore City, MD. 22, Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licenses 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ovona. disease or condition resulting in death) /Medical Examiner Nelkana if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and s the burial-transit avenus that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has autopsy performed Vital 1 ☐ Yes 2. No 1 Yes 2 □ No the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Division of this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Territying Physician: 10 the best of thy knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of co rtifier 29d. Date signed (Month, Day, Year) 4 30. Name and address of n who completed cause of death (Item 23a) (Type, Print) Ali Sinai 6730 Holabird Avenue, Dundalk, Md. 21222 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 14830 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year larie Physician Elizabeth Wolf 7:00 A M P035 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Riverview Nursing Home Baltimore Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 TyF 97 February 24,1907 MD Director 218-14-0682 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Dundalk MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 IISA 7504 Lawrence Road Funeral or than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Im 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory years Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cuniqunda Litz John Wolf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7504 Lawrence Road, Dundalk, MD. 21222 Niece Genevieve Holland Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, Stete 20a. Method of Disposition permit. Pages 1
Department of He
Important: if iter
any injury or oth 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore City, MD. May 6,2004 Holy Redeemer \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7,7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not inter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclowic Coronar Obserla D. Leave Hyporteusuce Physician ugast disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Chronic Olstrocture Polomon 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an emoutia page 2 autopsy performed? 014 certificate 1 ☐ Yes 2 ☐ No ) steaporons 1 Yes Core boal 2 🐼 No angonson Was case referred to medical examiner? Be 25. 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 LNursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t Certification: 27. Manner of Death Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kenseyens Michael D19667 05-04-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Petetine Highway \* 508 Cleu Bs: wie, otalland 21061 Kulent 60 Theread. 7310 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souls Registrar WAX 0 7 2004

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2 1) 1 14831 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** April 30, 2004 Doris B. Wilson 11:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Oakcrest Village Baltimore Baltimore 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F 190-34-3302 89 Director Jan 10, 1915 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avant. It e Medical Examinar must be notified at 10d. Inside City Limits MD Baltimore Baltimore Director 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Blvd #4207 or Items 23a 21234 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3X Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry if Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be 1 nent of Health and Mental 1 Edwin F.K. Brower Mary M. Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Michael/daughter 2109 Eastridge Road Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21 Surviture of Juneral Service I cense State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** critica /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): to the Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the 9□ Unknown signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CUT 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 2 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1-Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide 24 hours a 12 Certifying Physician. To the best of thy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai within 24 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800

State Registrar

31. Date filed (Month, Day, Year) MAY 0 7 2004

32. Registrar's Signature

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygien 2 1 1 1 - For State Registrar 16832 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Yeer Charles John Zaledonis , 2, 2004 5:58 P M Jr. May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 813 Briar Hill Place Apt. I Essex Baltimore Co. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1⊠M 2□F Months Days Director 219-50-0789 56 Nov. 12,1947 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location \*how 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28e-1 shov treumetic event, the Madical Examinar must be natified at 1 ☐ Yes 2 XNo Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 Briar Hill Place Apt. I 21221 death 1 United Funerai States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∑Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: 1967-70 ģ Specify 3 ☐ Widowed 4 € Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Supply Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill iment of Health and Mental Hitem 27 is marked others. Be Charles John Zaledonis, Sr. Genevieve L. Parysz Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Genevieve L. Zaledonis 2722 Plainfield Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 5/6/2004 Rosedale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician musican dias /Medical Due to (or as a consequence of): **Examiner** per lensure Cardis vaccular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes ≥ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? (es 23No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
Yes 2 No Hospital: Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) Hospitel or Attending Pl
 24 hours after death.
 Funerel Director: After th 27. Manner of Death 28c. Injury at Work? 28h Time of Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel E 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10007632 00 4 Othrovan, rossor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Time Ross And O'Den OV And OD 2012 DUNDALK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 95 O T OL 55 AM **Physician** 2004 heophia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** n/a Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. August 23, 1925 Birthplece (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K 78 213-20-0907 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore Director n/a the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21214 USA 2915 Glenmore Avenue "natural", or items 23a 2 should be filed within 72 hours after death wand Mental Hygiene. Be Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Marned White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tavern Co-owner 8 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Not known mit. Pages 1 and 2 should be partment of Health and Menta portent: If Item 27 is marked y injury or other treumatic ev Michael Zitzky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5396 Bittinger Rd., Swanton, MD 21561 Yvonne McConnell-daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Hill top Service Corporation 5/12/04 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, MD permit. Page Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 21. Signature of Funeral Service Licensee William G. Dau 5305 Harford Rd., Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 200515 /Medical Due to (or as a consequence of) **Examiner** trial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included executions) Due to (or as a consequence of) Physician/Medical Examiner for use as the burial-transit sowel that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68769 the attending physicial or Attending Physicien: The law requires that the death certificate be-IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by ed bluods 4 Unknown 2 🗆 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate has page 2 rmed7 2 No 1 Yes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 □ FR/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 🗌 No 1 Yes investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES000 M.D. 05/07/04 N. MELEUOI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Baltimore MO 5601 Raven Lock N. Mejevoi 31. Date filed (Month, Day, Year) 32. Registrar's signature State MAY 1 0 200 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:40 AM Swor Edward May 04 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner 1A Medical Center Baltimore Baltimore Hours Min. Reb. 6, 1934 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 9. Birthplece (Stete or Foreign **Funeral** Days Months 1⊠M 2□ F Maryland Director 212-30-8993 70 Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County Show items 23s or 28s-f short ner must be notified at Reisterstown 1 ☐ Yes 2 ☐ No Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 423 Valley Meadow Circle Apt A4 21136 Completed by Funeral U.S.A.

14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 1X Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter David Ray 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Peges 1 end 2 should be fill tment of Health end Mental H tant: If Item 27 Is marked oth Wesley E. Ball Rosie E. Ray 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David Ray- Step-brother 4212 Berger Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of H Important: if ite any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5/10/04 Laurel, Maryland 4 Donation 5 ☐ Other (Specify) Balt/Wash. Crematory 22. Name and Address of Fecility Miller-Dippel Funeral Home, Inc. re of Funeral Service Licensee 21, Signa 6415 Belair Road Baltimore Maryland 21206 23a. Part Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, br heart failure. List only one cause on each time. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical **Examiner** Examiner buriel-trensit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Tyes 245No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA edical Certification: To 28c. Injury et Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Neturel 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No death. within 24 hours efter death To the Funeral Director: A completely filled in by the f 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State MAY 1 0 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BLOWE WILLTAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NOGA TINS MORNE If Under 24 Hrs. Jast birthday) If Under 1 Year 9. Birthpleca (State or Foreign Country), 5. Social Security Number 7. Age (In yrs. **Funeral** Min. Hours 213-70-123 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Ashland USA 21205 natural, or Itams 23a by Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Marned Specify: Black Baltimore, Maryland 21215-0036 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other then eny injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Driver lath 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blowe William P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - mother 2325 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Mein. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 23a. Pert1. En la the disa shock of heart failu Immediate Lause (Final disease or condition resulting in death) the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between the disease, or com leart failure. List only or complications that caus diti ist only one cause on each line Onset and Death PULMONARY HYPERTENSTON **Physician** TWO month /Medical Due to (or as a consequence of): **Examiner** Two Years RETROVIRAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit and Due to (or as a consequence of) Box 68760, physician Physician/Medicai the attending IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţoţ in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 I Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 1 Yes 2 No 1 ☐ Yes filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funaral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MEDICAL POCTOK RES-000 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JORDAN PRUTKEN 600 N. WOLFE STREET TOWER 110, BALTIMONE MARYLAND 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Brown **Physician** 05 03 2004 23:09 M atherine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Ctr. Johns Hopkins Bayview Med. N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 1 M M F 219-32-4103 Director 67 Feb 27, 1937 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23s or 28s-1 ehow any Injury or other traumatic event, the Medical Evaluations must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore 1X Yes 2 No Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3434 Dudley Ave. 21213 U.S.A Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ₩ Widowed 4 Divorced Black Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore City Schools** Food Manager 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Foster Sadie Foster 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Brown 3434 Dudley Ave. Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) faite 2. Name and Address of Facility 21. Signature of Funeral Service Licenses Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 Este 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and De Immediate Cause (Final Gastro-intestinal bleeding 2 days **Physician** disease or condition resulting in death) /Medical **Examiner** Bowel ischemia 3 wks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.O. I detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Cardiomyopathy 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 🗆 No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient Medical Certification: To 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) opour RES - 000 05/03/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Baltimore, MD 21224 4940 Eastern 10 31. Date filed (Month, Day, Year) 32, Registrar's Signature State MAY Registrar 2004

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8	ral', c	l by	3 ☐ Widowed 4 ☐ Divo	rced	If Yes, Give Year or Dates:			1□Yes 2	ĭ <b>X</b> (No	Specify:				Specify: B	lack	
21215-0036	within 72 hours after death with the Maryland ane. than "natural; or Items 23a or 28a-1 show the Madical Exaction for the Excition of	Completed by	15. Dec (Specify only h	edent's Educa ighest grade			16a. Deced (Give	dent's Usual kind of work DO NOT use	Occupa done di	tion uring most	of workir	ng	16b. K	ind of Business/	Industry	
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	and 2 salth n 27 I		Rose A. Buc	ksell	L-Wife						Hig:	hway #		) Siver	-	
ore	es 1 of He If iten		20a. Method of Disposition 1∑ Burial 2 ☐ Cremat	tion 3.⊟Re	moval from State	20b. Pl	ace of Dispo imetery, cren	sition (Name natory or oth	e of ner place	)	D	ate	20c. L	ocation - City or	Town, State	Md.
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Baltimore,	permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumetic event, Ite Medione.		21. Signature of Funeral Ser	B B	alung	·.		. Name and Chinn				ervice	26 Ar	05 S.S	Shirli 22206	ngto Rd
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	/Medical Examiner		resulting in death)		Due to (or as		•		)	+ 1		-+		1	1	
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Вох	ath ce ttendi or use	an/	23b. Was decedent pregnan in the past 12 months?	t 23d	<ol> <li>If yes, outcome 1 ☐ Live birth</li> </ol>			Ectopic preg	gnancy					23d. Date of deli Month	-	Year
o.	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of de	ath 5	Other (spec	cify)					MONTH	Day	1 bai
P.O.	that the	Ph	Part II. Dther significant cor	iditions contr	ibuting to death b	ut not resul	Iting in the ur	nderlying cau	ise diver	n in Part I.		23e. Did to	bacco u	ise contribute to	the cause of c	death?
Vital Records,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	d by					•	,	3				es 21		obably 4 🗆	
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0	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 SNatural 5 □ Pe	anding	28a. Date of Injur		28b. Time of Injury	280	c. Injury a	at		8d. Describe ho			,	
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Division of	or Att	Certification;		ould not be itermined	28e. Place of Inju- building, etc	ury - At hor c. <i>(Specify)</i>	me, farm, stre	et, factory,	office		2	8f. Location (St City or Town		d Number or Rui )	ral Route Num	ber,
	To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the		29a, Certifier 1 ★ Cert	ifving Dhyel	cian: To the best	of mu know	lodge dest		the Alex	date = 1	4					
	e Hos 24 hc e Fun etely	edical	(Check only 2 Med	icel Exemine	r: On the basis of and manner sta	examination	on and/or inv	estigation, in	n my opi	nion, death	piace, ai	d at the time, d	ause(s) ate and	place, and due	stated, to the cause(s	)
	To th. Within To th.	Me	29b. Signature and title of ce	rtifier					License			2	9d. Dat	e signed (Month,	, Day, Year)	
			> ytenry	马子	X W	<b>D</b> .		1 2	819	46			5/	10/0	4	
	P		30 Name and address of per	son who com	pleted cause of d	eath (Item	23a) (Type, I	Print)	5+	NW	W	ashing	to	- DC	2003	57
	Sta Registr		31. Date filed (Month, Day, Y	<sup>(ear)</sup> 2004	32. Registra	ar's Signatu	ure G						<del>)</del>			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Elizabeth Carrigg May /Medical 2004 8:55 p 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 4b. City. Town, or Location of Death 6334 Cedar Lane Columbia Howard If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 10 M 2 F 217-44-8914 Director 58 8, 1946 Washington, Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. The file at 18 and 23a or 28e-f show then treamstic event, the medical Examination by collings at other treamstic event, the Medical Examinations. Director 1 X Yes 2 □ No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Cashier Drugstore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menia Important: If Item 27 is marked any injury or other traumatic ev Robert Green Betty Guilde 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Winstead/Son 1837 Sutton Avenue, Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cem. <sup>3</sup> 4 □ Donation 5 □ Other (Specify) 5/10/2004 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00160 313 Talbott Avenue, Laurel, MD 20707 ana 23a. PartY. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease **Physician** /Medical Due to (or as a consequence of): Examiner Senile Dementia Sequentially list conditions, any leading to in additional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery ō 3 DEctopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death signed by the a 5 Other (specify) ☐Yes 2☐No P.0. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2√2 No 1 Inpatient 2 ER/Outpatient 3□ DQA this Director: After that in by the funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. injury at Work? 1 X Natural 2 ☐ Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospitel within 24 hours a To the Funerel D filled Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30641 May 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Saba athi, ND 201-109 Back River Neck Road, Baltimore, MD 21221 32. Registrar's Signature State Registrar

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			5	state of Maryland			ı Mentai Hy	giene		
			AMEND ITEM #3 PER PHYG	831 5/10/04 JH	Certifica	te of Death		Reg. No. 2	004 11	870
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	ChERTIC	pood		2. Dete of De Month	Day 13	Year 3. Tirhe of 1:48r	
	Examir		4a Pacility Neme (fi not Institution, give stra	et end number)	)   /	4b. City, Town,	or Location of Deat	4c. County		
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	Funeral Director		30 72 (304	200 F 7. Alge (In yrs. le	Yrs. If Und	er 1 Year III Under 24 H s Days Hours M	Irs. 8. Date of Bir in. Month, De	1 (9/7	9. Birthplace (State or Country) Alabama	r Foreign
	and *		Usuel Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location				10d. Inside Cit	ty Limits
	Aenyla P sho	ō	m.D Frederic	$\sim$	)				1 ☐ Yes	
	the A	Director	10e. Street end Number	K //	10NR DY/A	ip Code		10g. Citizen of V	Vhat Country?	
	with a se	ā	11755/0 )=1/=0 L	/1/1)		21770		11	10	
	leath	era	11 Marital Status 12.	Was Decedent Ever in U,S		edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No	14. Raci	e - American Indian,	
21215-0020	ges 1 and 2 should be filed within 72 hours after death with the Meryland at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	THE WATER STORES	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, sp 1 □ Yes	. 1	erto Rican, etc.)	Specify	k, White, etc.	
0-0	2 hou	2	15. Decedent's Educati		16e. Decedent's Us	ual Occupation		16b. Kind of Bu	siness/Industry	
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21	d with giene. rr than	ĕ	12	0	hous	ewife		own	home	
pu	be filed tal Hygi d other	Be	17. Father's Neme (First, Middle, Last)			18. Mother's N	lame (First, Middle	, Maiden Sumam	э)	
Va	should be and Mental is marked or umatic eve	2	Bruce Copeland Mat	tison			Eunice Ra	msey		
Maryland	2 sho and is me		19a. Informent's Name/Relationship (Type,	Print)	-	ss (Street and Number or				
	1 and 1 Health em 27		Don Cheatwood/son			erside Drive				
Baltimore,	Pa Interior		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion 3 ☐ Rem- 4 ☒ Donetion 5 ☐ Other (Specify)	CO	ace of Disposition (N metery, cremetory or	ame or rother plece)	Date	20c. Location -	City or Town, State	
Balt	permit. Pages Department of Important: If It any Injury or once.		21. Signature of Funeral Service Licensee Ronald S. War	Director	State	and Address of Facility Anatomy Boa nore, MD 21	rd 655 W. 201	Baltimo	ore Street	
			23a. Part1. Enter the diseese, or complicate	ons that caused the death.				rrest,	Approximate Interval Betw	3
	Physician /Medical		shock, or heart failure. List only one of Immediate Ceuse (Final disease or condition	Consider the	ine La	La La	11110		Onset and D	Death
	Examiner	Jer	resulting in death) a	Due to (or	as a consequence of	f):	4/ 4/-			
	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the bunei-trensit	edicai Examiner	Sequentially list conditions,	Due to (or	as a consequence of	1.				
0	e exe	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
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	ires thet the death cert signed by the ettendin d be deteched for use	Physician/M	Pert II. Other significant conditions contrib	uting to death but not resul	lting in the underlying	cause given in Part I.	23b. <b>Di</b> d	tobacco use cor	ntribute to the cause o	f death?
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Sic	Attending or death.	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor			28f Location /	Street and Numb	er or Rural Route Numl	ber
Division	or At effer Direc	Certification:	4 Homicide determined	building, etc. (Specify)		sry, office	City or To	wn, Stete)	J. 0. 1   0. 1	,
	To the Hospital or Attending Phys within 24 hours effer death. To the Funerel Director: Affer this completely filled in by the funeral di	edical C	29a. Certifier (Check only one)  (Check only one)  (Check only one)	an: To the best of my know On the besis of examination and manner stated.	vledge, deeth occurre on end/or investigation	od et the time, date and pla on, in my opinion, death or	ace, and due to the occurred at the time,	cause(s) and ma date and place, o	nner as stated. and due to the cause(s)	)
	o the o the omple	¥	29b. Signature and title of certifier		2	9c. License number		29d. Date signed	(Month, Day, Yeer)	
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			30. Neme end address of person who comp	leted cause of death /Item	23e) (Type, Print)	00,0	1		1-9	
			65 C Thomas		. 7.	Freden	ck m	0 217	02	
ne"	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signet		, , , , , , , , , , , , , , , , , , , ,		- 47		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 930 PM M **Physician** MARLEME ColteN MAI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** COLUMBIA HOWARD 5126 HESPERUS DR. If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) MAR 21, 1 Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 □ F MARYLAND 1938 219-26-7639 66 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Exercity must be notified at once. 10b. County 10c. City. Town or Location 1 Yes 2 □ No **Funeral Director** HOWARD COLUMBIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 5126 HESPERUS DR. 21044 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: t Never Married 2 Married 1 Tes 2 No WHITE Baltimore, Maryland 21215-0036 Specify Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **SCHWARTZ EMANUEL** MABEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ARTHUR COHEN (HUSBAND) 5126 HESPERUS DR. COLUMBIA, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation COLUMBIA MEMORIAL PARK 5/7/04 COLUMBIA, MD 4 □ Donation 5 □ Other (Specify)

21. Signature 3 Funeral Service (Canso 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest.

Appr. 12 9.6 shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ANAPLASTIC THYROID CANCER Immediate Cause (Final METASTATIL Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physician IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 WNo certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death To the Funerel Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 1-34868 Lewys 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pankung. 11055 LIHLE PATURENT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 0 2004

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			Registrar  1. Decedent's Name (First, Middle, Last)		COIL	meate or	Death	2. Date of Dea	Reg. No ath	. 2 0 0 .	3. Time of Death
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	arylar	_	10a. State 10b. County	10c. City, Towr	n or Loca	ation					10d. Inside City Limits 1 ☐ Yes 2 No
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	be filed within 72 hours after death with the Maryland Hygiene. Hygiene de Hygiene de other than "natural", or Items 23a or 28a-f show do other than "natural", or Items 23a or 28a-f show event, the Machel Examiner must be notified at	Funeral	916 N. Marlyn Aven	UE t2. Was Decedent Ever in U.S.	12 W	21221	lienanic Origin? (S	pacify Vac or No.		S. A.	ancan Indian
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Maryland 21215-0036	ges 1 and 2 should t of Health and Men i If Itam 27 Is marks or other traumatic		19a. Informant's Name/Relationship (Ty				and Number or Ru				
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	74 G 40		23a. Part1. Enter the disease shock, or heart failure. List only or	collons that caused the death. Do n	not enter	the mode of dvin	astern Av	or respiratory ar	rest.	., Maryi	Approximate
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	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical		sicien: To the best of my knowledge ner: On the basis of examination and							
	thin 2 the orthe	Med	29b. Signature an June of certifier	and manner stated.	1	29c. Licens	e number		29d. Dat	te signed (Monta	h. Dav. Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** C Linwood MAY 5:50 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner C: ty Baltimore Sing: Itospital 50 Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month Day, Year) Jan 8, 1916 Birthplace (State or Foreign Country)
 VII 6. Sex **Funeral** Months 1 □ yM 2 □ F 218-09-3988 88 Director Usual Residence of Decedent 7 is marked other than "natural", or Itams 23a or 28a-f ahow traumatic avent, It a Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore Director 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3602 Clifmar Road 21244 USA Funeral 12. Was Decedent Ever in U.S.
Amed Forces?
1 Yes 2 No
If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married D c c (y) = 10 W c c X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced WWII Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If itam 27 is marked of Eugene Doody Bertha Burns 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Grace G. Doody (Wife) 3602 Clifmar Road Baltimore, MD 21244 othar 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mt. Olive Cemetery X Burial 2 Cremation 3 Removal from State injury or 5/13/2004 Randellstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses HATCHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration MACHMONIA 7 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner attending physician and for use as the burial-transit be executad Due to (or as a consequence of): Box 68760 Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year P.O. 1 5 Other (specify) the 9□ Unknown 9 Unknown Š signed b d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by disease, 1 Yes 2 No 3 Probably 4 Donknown hyperterlion 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

To the Hospital or Attanding Physician: After death. Diractor: hours after within 24 hours a'

Certification: To Medical

3 Suicide 4 - Homicide 29a. Certifier (Check only one)

2 Accident

investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

RES-000

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and a erson who completed cause of death (Item 23a) (Type, Print) Keller 20 homas

Itospital of Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature 1 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** William M. Davis 5 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAITIMORE Kose FRANKLIN 5. Social Security Number Vose (A) = Under 1 Year | If Under 24 Hrs. SUARE 170501 1A 8. Date of Birth
July 15, 1949 9. Birthplace (State or Foreign Mar 9 141) (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 54 214-50-4332 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Baltimore N/A Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21214 2805 Hemlock Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status Peges t and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 XYes 2 Novietnam If Yes, Give Vietnam Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Baltimore City 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna C. Gohlinghorst William Mack Davis Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 Hemlock Avenue Baltimore Maryland 21214 19a. Informant's Name/Relationship (Type, Print) Jennifer A. Davis/Wife 27 permit. Peges t and Department of Healtl Importent: If item 27 any injury or other 1 QMCE. 20b. Place of Disposition (Name of cometery, crematory or other place)
Hilltop Service Corp. 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/13/04 Towson Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland husling 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leeding to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Hospitel or Attending Physician: The law requires that the death certificate he say Division of Vital Records, P.O. Box 68769 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 Z No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural
Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contine D55000

State Registrar

legistrar MAY 1 0 2004

DR. Todd

31. Date filed (Month, Day, Year)

DER 9000 FRANKLIN SQUARE DR. BALTIMORE Md 21237

32. Aggistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LARAbee

ORIGINAL

Physici	an	Decedent's Name (First, Middle, I	.ast)		SAGU		2. Date of Death Month	No. 20 (	3. Time of Dea
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27 lg		Martha D. Erskine	e/ Wife				Fulton, Ma		
er ber		20a. Method of Disposition 1 🗆 Burial 2 🚾 Cremation 3	20b. F	Place of Dispo	sition (Name of matory or other place	)		. Location - City of	
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Godman 6:32 AM Marline 2004 Mar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospital Baltimore

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. N/A8. Date of Birth (Month, Day, Year)
Tan. 17, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 220-36-9079 65 Yrs. Jan. Director 1939 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Exercited mat be notified at Funeral Director MD N/A 1 XYes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if tiam 27 is marked other than "--- any injury or other traumette." 2228 Presstman Street 21216 S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: Specify: Black 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) St. Agnes Hospital Dietary Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dennis Taylor, Sr. Alverta Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Taylor-White 2228 Presstman St. Balto., MD 21216 20b. Place of Disposition (Name of Garrisson Forest Veterans Cem. 20c. Location - City or Town, State Owings Mills, 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 5/12/04 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Foneral Service Licensee Drade Meron 2501 Gwynns Falls Pkwy. Balto., MD 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END Starl Chronic Obstructive Dulmongin Physician /Medical Due to (or as a onsequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Attanding Physician: The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy detached for Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗹 No 3 Probably 4 □Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2/4 No certificate 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 walco Name and address of person who completed cause of death (Item 23a) (Type, Print) STreet, TIMOIA 2000 West Baltimore ilardo USUMO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State food Registrar 0

DOS 04-3055 Howard Green

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ra	Green		For State	State of Mary					ntai Hyg	iene 21	104	1101-
			Registrar		Cei	rtificate	of Death			g. No.	04	1484
	Physici	an	Decedent's Name (First, Middle, Last					2	. Date of Deat Month	h Day	Year	3. Time of Death
1	/Medic		HOWARD W	ILLIAM G	REEN SR			N		2004		1452 p <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or Location o	of Death		4c. County	of Death	1.0
			University Ho	spital		Balt	imore				N	1/14
	Funeral		5. Social Security Number 6. S	ex 7. Age (II	yrs. last birthday)	If Under 1 Months	Year If Under 2 Days Hours	24 Hrs. 8	Date of Birth (Month, Day,	Vearl	9. Birthpl	ace (State or Foreign try)
	Director		216-30-1214	<b>Ж</b> м 2□ F	67 Yrs.	NOTIUIS	Days	WIIII.	6/4/19	936	MAR	YLAN D
	р		Usual Residence of Decedent									
	how I		10a. State 10b. County	10	c. City, Town or Lo	cation					10	Od. Inside City Limits
	Ma B-1-8	Ş	MD BALTIN	IORE	RANDAL	LSTOW	IN					1 ☐ Yes 2 ☐ No
	r 28	ire	10e. Street and Number			10f. Zip C	Code		16	g. Citizen of W	/hat Count	try?
	h wit	o ie	3801 SCHNAPI	ER DR, APT	. 407	21	233			US	SA	
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show deal Evandar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decede	nt of Hispanic Orig y Cuban, Mexican	gin? (Speci	y Yes or No-		- America	
9	or Ita	F	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 □ No If Xex Give	KOREAN			i, rueito ni	can, etc.)		k, White, e	
03	es	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	KOKLAN	¹∟Yes 2n	XNo Specify:			Specify	BLACE	`
21215-0036	2 ho	Completed	15. Decedent's Ed			dent's Usual	Occupation done during most	e of working		16b. Kind of Bu	siness/Ind	ustry
2	within 7 ena. than "r	ple	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use	retired)	t of working		IIC DO	CONTA	-
2	filed with Hygiena. Ithar thar	PO			EDC D	OST C	FFICE (	T EDL	,	US PO SERVI		J
	I Hygie othar	Be	17. Father's Name (First, Middle, Last)	CORTEZ PET	EKS F	051 0	18. Mothe	or's Name (	irst, Middle, N	SERVI faiden Sumami	9)	
<u>a</u>	lid be lenta	To B	HOWARD GREI	EN			RO	OSE	COOK			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiens. item 27 is marked other than "natural", or Itams 23a or 28a-1 show item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic avant. I'm Medical Exarch per notal the notified at	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (	Street and Numbe	or or Rural F	Route Number,	City or Town, .	State, Zip (	Code)
Σ	and 2 ealth a n 27 is		DAISY GREEN	WIFE.	3801	SCHN	APER DE	R. AF	т 407	RANDA	T.T.ST	21233 TOWN, MD
ē,	of Health itam 27		20a. Method of Disposition		Ob. Place of Dispo	sition (Name	of	Dat		Oc. Location -	-	
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer METRO C	REMAT		5/10	/2004	MARYLA	MD	
₽	artme artme ortar injur		21. Signature of Funeral Service Licer	<u> </u>			Address of Facility		-	UNERAI		A E
Ba	permit. Page Department of Important: If any injury or once.		Richard	X/201000			JBERTY	1101				21207
			23a. Part1. Enter the disease, or com	plications that caused the								Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	iii. 94		143			W		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a luperknsive		cticcos	discourse	ise se	anplicate	o by one	nia	
*	Examiner			e to (or as a co	onsequence of):				2.0	0		
		<u>_</u>	Sequentially list conditions.	b. Due to (or as a co	W. Commission of the Commissio						_	
	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	orisequence ory.							
_	and I-trar	хап	that initiated events resulting in death) Last	c. Due to (or as a co	negatience of).						_	
8760,	ate be executed hysician and the burial-transit			545 (5) (5) 45 4 50	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
		Physician/Medical		. d.								
9 X	ing p	Me	IF FEMALE:	00- 16							1	
Вох	attending for use a	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic preg				23d. Date Mon	of deliver	y Day Year
	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□ Unknown	e of death 5∟	Other (spec	cify)				-	,
P.O	that the ded by the detached	Phy		antibution to doub but a	at requision in the		on succes in Doct I		220 Did tob	2000 1100 00011	buta to the	e cause of death?
Ś	res that igned b	by	Part II. Other significant conditions of		-			4.6				4
orc	w requir been s should	Completed	herbiser 1 1820	was dise	use , au	cobet	> menin	in a	1 10	s 2 □ No	3 Proba	bly 4 Unknown
ec	has be	pje							24a. Was an autopsy		lere autop	sy findings available ipletion of cause of
<u>m</u>	The ate has page	Om							perform	ed? d	eath?	2□ No
Vital Records,	ilcian: Th certificate rector, pag	e)	25. Was case referred to medical				26. Place	of Death (0	Check only one			
f \	ys Si Gill	To B	examiner? 1 - Yes 2 - No	Hospital: 1 ☑ Inpatient	2 ER/Outpatien	it 3□ DOA	Other: 4 Nur	rsing Home	5 🗌 Resider	nce 6 Othe	r (Specify)	
	ding Ph .r After th funaral		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	280	: Injury at Work?			w injury occurre		
jo		atio	1 Natural 5 ☐ Pending investigation		mjury	М	1 ☐ Yes 2 ☐ N	No				
Division	or Attan after deatl Director: in by the	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury	At home, farm, str	eet, factory,	office	281	Location (Str. City or Town,	eet and Numbe	r or Rural	Route Number,
	al or A	Certification:	4 - Homicios	building, etc. (5	pecny)				City of Town,	Sidle)		
	To the Hospital or Attan within 24 hours after deat To the Funaral Director: completely filled in by the			ysician: To the best of m								
	e Ho e Fu letely	edical	(Check only 2 ★ Medical Exan	niner: On the basis of exa and manner stated		vestigation, ir	n my opinion, deat	th occurred	at the time, da	te and place, a	nd due to t	the cause(s)
	Vithin of th	Me	29b. Signature and title of certifier	(	200	29c.	License number		29	d. Date signed		
	->-0		Mot. ()	ion : -	SULLA	~	OCME			May 6,	2004	
г	15		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)						
	7		Pare al Ar	NICA-Pal	INKLIE	7 111	Penn St	reet,	Baltin	nore, Ma	aryla	nd 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	Signature							
	Registr	•		0 2004	he he	do						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Y 3, 2004 **Physician** ANNA VERONICA MAY HOCK 1:38 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3233 FAIT AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
OCT. 7,1915

8. Birthplace (State or Country)
MARYLAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X0XF 215-01-4943 88 Yrs. Director Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 □ No MD. N/A BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or The Medical Examiner must be r 3233 FAIT AVENUE e filed within 72 hours after death val Hygiene.
other than "natural", or Items 23e 21224 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify: ģ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOUSEWIFE DOMESTIC peinit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: If them 27 is marked other and any injury or other traumatic event 2011. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN WANGER CRESCENTIA ADELMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY J. HOCK/DAUGHTER 3233 FAIT AVENUE BALTIMORE MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 5/8 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee ZEILER INC. FUNERAL HOME CONKLING STREET, BALTO., MD LILLY & 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Don ARTENIOS CHENT'S CARDION Mal Physician ч /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ TE D ANTHAL 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 s autonsy performed? (es 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this nours after death. neral Director; After this rilled in by the funeral d 27. Mariner of Death 28a. Date of Injury (Month, Day Year) 28d. Di scrille how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24276 MU 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIMON V. SCALIA, M.D. 2801 HUDSON STREET, BALTIMORE, MD. 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 0 2004 > Registrar

		Registrar APEAU LIETT #3  1. Decedent's Name (First, Middle, Las.)	PER FH C831 5/25/04	Jaerun	Jale Of L		2. Date of Death		3. Time	of Death
hysici		Annette	Jean		Hofi	=	Month April	Day 2.6 2	Year	00p.
/Medic Examin	_	4a. Facility Name (If not institution, give		4b.		Location of Death		4c. County		
		8 Three Willow	Ct.		atons			Bal	timore	
ineral		5. Social Security Number 6. Se 219 -30 -5172	TM 2575		Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State Country)	or Fore
rector	}	2-1-9-80-5172 Usual Residence of Decedent	71	113.			11 26	32	MD	
Mot		10a. State 10b. County	10c. City, Tow	n or Location	1				10d. Inside	-
a-f a	ctor	MD Howard	Colu	mbia					1 🗍 Ye	s XŽ
or 28	Director	10e. Street and Number		10	f. Zip Code		10	og. Citizen of	What Country?	
230	<u>ē</u> 1	0529 Morning Wi	nd Lane 12. Was Decedent Ever in U.S.	12 Was I	2104		pecify Yes or No-	U.S	• A •	
Hen I	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	If Yes	, specify Cubar	, Mexican, Puert	o Rican, etc.)		ck, White, etc.	
P. o.	by	3 XWidowed 4 ☐ Divorced	It Yes, Give *** Year or Dates:	1 U Y	es 2XX No	Specify:		Specif	y: Black	
acal	Completed	15. Decedent's Ed (Specify only highest grad		(Give kind	Usual Occupa of work done di	ring most of wor	king	18b. Kind of B	Business/Industry	
u W	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		OT use retired)		D	-1-3	Oi b	
ther t		12th grade	4yrs	T'e	acher	18. Mother's Nan	B ne (First, Middle, M		ore City	
o pes	o Be		3				William		,	
mat	ဥ	Charles Richard 19a. Informant's Name/Relationship (7		o. Mailing Ad			ral Route Number,		, State, Zip Code)	
Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar count be notified at		Ronald Hoff-Sor	8	T.hre	e Wil	Low Ct.	, Caton	svill	e, Md 21	228
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	20b. Place o cemete	f Disposition	(Name of y or other place	)	Date 2	20c. Location	- City or Town, State	
ant: h ury o		*4 □ Donation 5 □ Other (Specify	1	ison	Forest	. Vet.	4/30/04	Owin	gs Mills	. 1
Important; I sny injury o once.		21. Signatule of Funeral Service Licens		22 Nar	ch F/I	s of Facility				St.
- a a	1	Julynes	Dreke	430	O Waba	ash Ave	, Balti		Md 2121 Approxim	
		23a. Parti. Enter the disease, or comp shock, or heart alure. List only of Immediate Cause (Final	one cause on each line.		_	, such as cardiac	or respiratory arre	ist,	Interval B	etweer
sician edical		disease or condition resulting in death)	a	ARI	MAC	AR	REST			
miner			Due to (or as a consequence	or):	TRD10	mins	ATTHE		546	20
-	Je	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):	614.510	1	7	4		7-
nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. D1	ABE	158		V		54	RI
physicien and the burial-transit		resulting in death) Last	Due to (or as a consequence	of):					tio	10
physic the t	dica		d	TIN					34	14
attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy					23d. Da	ate of delivery	
d for u	iciar	in the past 12 months?	1□Live birth 2□Fetal death 4□Pregnant at time of death		pic pregnancy er (specify)				onth Day	Year
ed by the detached	hys	9 Unknown	9□ Unknown							
5 8	ру Р	Part II. Other significant conditions co	ontributing to death but not resulting i	n the underly	ring cause give	n in Part I.			tribute to the cause of	
been si							1 □ Ye	s 2 No	3 ☐ Probably 4 ☐	Unkno
2 2	Completed						24a. Was an autopsy	,	Were autopsy finding prior to completion of	s availa
pag							perform 1 Yes 2	No	death? 1 ☐ Yes 2 ☐ No	
this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		Othe	r-	th (Check only one	4347.7	Sam	É
or this aral di	-	1 ☐ Yes 25€No 27. Manner of Death		Time of	28c. Injury	at Nursing H	ome 5 Resider	_	ner (Specify) >07V	JOE
tor: After the funer	ation	Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury M	Work 1 □ Y	? es 2□No				ب ا
Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, f	actory, office		28f. Location (Str. City or Town	eet and Numb	ber or Rural Route Nu	mber,
led in			,							
To the Funaral Direct completely filled in by	edicai	(Check only 2 Medical Exam	vsician: To the best of my knowledge liner: On the basis of examination an	e, death occ nd/or investig	urred at the time ation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and ma te and place,	anner as stated. and due to the cause	(s)
To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signe	ed (Month, Day, Year)	
		wedy 14 Cli	Dhun					_		
⊢ ŏ										and the same of th
5-1		30. Name and address of person who o	completed se of death (Item 23a).	(Type Print)	200	8924 Kory R		00	28200 Jumbia 21044	10

			For State	State of Marylar	nd / Depa	artment of H	Health and	-		
			Registrar		Ce	rtificate of	Death		Heg. No.	
	Physici /Media		1. Decedent's Name (First, Middle, La.  JOHN F. JAKUBO	WSKI		1		2. Date of De Month MAY	3, 2004	+  5:00 p <sup>M</sup>
1	Examir	ıer	4a. Facility Name (If not institution, give				or Location of Deat	h	4c. County of De	
			5. Social Security Number 6. S		last birthday		IMORE  If Under 24 Hrs	8. Date of Bir	N/	
	Funeral Director			ØM 2□F 7	5Yrs.	Months Days		(Month, Da	y, Year)	Birthplace (State or Foreign Country) ARYLAND
	yland		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Mar a-fal	Director	MD N/A	В	ALTIM	ORE				1 X Yes 2 □ No
	th the	)Ire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a		6715 BOSTON A	VENUE			222		USA	
	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28e-f ahow I'lle Medical Exama wr blust be maillied at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	J.S. 13.	Was Decedent of h If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - Al Black, W	merican Indian, hite, etc.
920	ours at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	WHITE
21215-0036	n 72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Busine	ss/industry
2	within ene.	dmc	Efementary/Secondary (0-12)	College (1-4or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	MACHIN	•		BETH S	rrrr
2 2	filed Hygi other		17. Father's Name (First, Middle, Last,			MACHIN		me (First, Middle,	, Maiden Sumame)	
an	Mental Mental arked c	To Be	ANTHONY JAKUB	OWSKI			STEL	LA SZCZ	ZERSKA	
Maryland	A DEE	-	19a. Informant's Name/Relationship (		19b. Maili	ing Address (Street		-	er, City or Town, State	, Zip Code)
	1 and 2 Health a am 27 is		MRS. CLARA JAK	UBOWSKI	6715	BOSTO	N AVE.	BALTIMO	DRE, MD.	21222
ore.	ges 1 and t of Heali if Itam 2 or other		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □		Place of Disponentery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State
Ĕ	Z a e a		`4 □Donation 5 □ Other (Specif	HO:	LY RO	SARY CE	ME. 5/7	/04	DUNDALK,	MD.
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licer	icnorowski					ME P.A. IMORE, M	m 21222
			23a. Part1. Enter the disease, or com	plications that caused the dea			-	-	The second secon	Approximate
	Dhysisian	ш	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		1				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Que to (or as a consec	rounce of):	Mury				one day
	Examiner	П		Condiac	Annes	et.				one day
$\leq$		Je l	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):	41				
	sician and burial-transit	Examine	that initiated events	c						
Ö,	e exe ian a urial-1		resulting in death) Last	Due to (or as a consec	quence of):					
8760	ate b hysic the bi	Ilcal		d						
x 68	death certificate t e attending physic d for use as the b	Physiclan/Medl	IF FEMALE:	23c. If yes, outcome of pregn	0.000					
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	aldeath 3[	☐Ectopic pregnanc☐ Other (specify) _	у		23d. Date of o Month	Day Year
o.	0 0 0	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	Jean 50	Other (specify)				š
۵.	The law requires that the to be been signed by the bage 2 should be detached.		Part II. Other significant conditions of	ontributing to death but not re-	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
of Vital Records,	quires n sigr	d by						The second second	Yes 2 No 3	Probably 4 Unknown
Ö	aw requir as been si 2 should l	olete						24a. Was		autopsy findings available
2	The la ate ha	Completed							rmed? death	
Ita		0	25. Was case referred to medical				26. Place of De	ath (Check only o		00 2/3 110
>	y S	ToB	examiner? 1 ☐ Yes 2 🔯 No	Hospital: 1 Inpatient 2	] ER/Outpatie	nt 3□ DOA Ott	ner: 4 🗆 Nursing H	Home 5 ☐ Resid	dence 6 Other (S	pecify)
	ding Ph h. After th funeral		27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Inju Wo	ry at rk?	28d. Describe I	how injury occurred	
<u>S</u>	death. ctor: A y the fu	catle	2 ☐ Accident investigation				Yes 2 □ No			
Division	I or Attending after death. Director: After in by the funer	ertification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location (3 City or Tox	Street and Number or vn, State)	Rural Route Number,
_	Hospita 4 hours Funerel tely filled	edical C		ysician: To the best of my kniner: On the basis of examinating and manner stated.						
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date signed (Mo	onth, Day, Year)
	- > - 0		Flin M	D		RES	-000		5-3-	2004
	()1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	, Print)				-
	10			4940 GASTET	W AUG		BAUTIMO	re m	0 2121	4
	Sta Regist		31. Date fill Month Dan Yearn 4	32. Registrar's Sign	aturo	رع				

Dhycia		<ol> <li>Decedent's Name (First, Middle, Las</li> </ol>	1 PER PHY		704		2. Date of I			3. Time of Deat
Physici /Medi		Benard Joseph Kuhn	Jr. BERN	NARD JOSEP	H KUHN,J	r.	Month May	Day 7 2	Year 2004	6:30 A
Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of			nty of Death	0.30 1
		502 Prospect Rd.			Mt. Air				erick	
Funeral Director		210-23-3371	**	e (In yrs. last birthday) 19 Yrs.	Months Days		Min. (Month, I	Birth Day, Year) 1, 1984	9. Birthplac Country Mary1	ce (State or Ford) and
M =		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d.	. Inside City Lin
hall Hygiene. Nat Hygiene. Ad other then "natural", or items 23a or 28a-f show event, tre Medical Examiner must be notified a	ē	Maryland Frederic	k	Mt. Airy						1 ☐ Yes 2 🔣
or 28g	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Country	?
23a	al	502 Prospect Rd.			21771			United	States	
i tems	nue	11. Marital Status	<ol><li>Was Decedent E Armed Forces?</li></ol>		Was Decedent of If Yes, specify Cut	Hispanic Origi ban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	No- 14. F	lace - American lack, White, etc	
10	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Spe		
atura	edit	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occu	pation		16b Kind of	Business/Indus	itn/
than "ng	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4 or 5	(Give	kind of work done DO NOT use retire	a during most a	of working	, , , , , , , , , , , , , , , , , , , ,	2011000411003	at y
Hygiene.	S E	Elementary, occorroary (b 12)	1	Studer	ıt			Virgi	nia Tecl	h
d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Midde	le, Maiden Sum	ame)	
snould be and Mental I s marked o	၉	Bernard J. Kuhn,					Lynn Myer			
4 00 -22 08		19a. Informant's Name/Relationship (7 Mary Lynn Myers Ki					or Rural Route Num		m, State, Zip Co	ode)
f Health itam 27 other to		20a. Method of Disposition	dilli (Flotile	A Section Control of the Control of			. Airy, M	-	n - City or Town,	State
0		1 ☐ Burial 2 ☑ Cremation 3 ☐		20b. Place of Dispo cemetery, crei		1		200. Locatio	ii - City or Town,	, State
		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Secretary</li> </ul>		All Count	y Cremat	ory 5/	10/2004	Sykesy	111e, M	)
Departr Departr Imports any inju		1.11/1/1		Bu	rrier-Qu	een Fu	neral Dire	ectors,	P.A.	
		23a. Part1. Enter the disease, or comp	lications that caused	the death. Do not ent	12 west	OLG 1/11	perty Rd.	Winfie	Ld MD 2	017Q4 oproximate
		Immediate Cause (Final	one cause on each lin	e. M.V.		-			Int	terval Between
hysician /Medical		disease or condition			POINT	10	Marian.		. Or	nset and Death
xaminer		resulting in death)	a Due to (or as a	a consequence of):	HZDIAL	- 150	chemia		2	nset and Death についいら
xammer			Due to (or as a	a consequence of):	SICINON	- 150	Chemia Live		2	nset and Death
	ner	Social Halfs for conflicts	£	1	GCINON	- 150	Liver		2	nset and Deat
	caminer	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):	HZDIAL OCINON	- 150 na of	Liver		2	nset and Deat
	ıl Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	denoco	OCINON	- 150 na of	Liver Liver		2	nset and Deat
	cai	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):	ACINON	- 150 nu of	Liver Liver	-	2	nset and Death
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н	Physici	an		ælat latta			Date of Death Month	Day Ye	3. Time of Death
3	/Medic		- Kafeeleat		Latta		day	3,2004	
	Examin	er	4a. Facility Name (If not institution, give street and nur	nber)	4b. City, Town, or Locatio			4c. County of D	
	<u> </u>	R	Howard Co. General  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Columbi		Date of Birth	How	
1	Funeral Director		216-23-1679 1 M 21XF	74 Yrs.	Months Days Hours		(Month, Day, Y	<sup>(eer)</sup> 30	Birthplace (State or Foreigr Country) Africa
	land ow		10a, State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary Feb	ţ	MD Howard	Colum	bia				1 ☐ Yes 2 X No
	r 28e	rec	10e. Street and Number		10f. Zip Code		10g	. Citizen of What	Country?
	h with	<u>~</u>	5634 Stevens Forest B	Road	21045			Africa	a
	ems 2	<b>Funeral Director</b>		dent Ever in U.S. 13.1	Was Decedent of Hispanic ( f Yes, specify Cuban, Mexic	Origin? (Specify	Yes or No-		merican Indian,
36	be filed within 72 hours after death with the Maryland ttal Hygiene.  Id Hygiene.  od other than "natural", or items 23a or 28e-f show event. If a Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 1 ☐ Yes If Yes, Giv	2 <b>X</b> No	1 ☐ Yes 2 ☐XNo Specia		,	Specify:	
8	hour tural	pe pe	3 ☐ Widowed 4 ♣ Divorced Year or Day  15. Decedent's Education		dent's Usual Occupation		1.00	b Kind of Duning	Black
21215-0036	in 72 n na	Completed	(Specify only highest grade completed)	(Give	kind of work done during m DO NOT use retired)	ost of working	16	b. Kind of Busine	ss/Industry
2	filed within Hygiene. Sther than "	E O	Elementary/Secondary (0-12) College (1 5th grade na		lf Employed	3		Self Er	mployed
	be filed ital Hygis of other event, II	Bec	17. Father's Name (First, Middle, Last)	122 222			irst, Middle, Ma		projeu
Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked o any njury or other traumatic eve once.	To E	Kehinde Habba KEINCE	HABEEB	Kaf	eelat	Habeek	)	
an	2 sho and is mu		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Num	nber or Rural R			
	and leaith m 27		Sidette Latta-Daught	er 5634	Stevens Fo	rest	Road	OLIMBIA, M COLUMB	ia Ma 210
0	ges 1 it of H if ite or ot		20a. Method of Disposition  5☐ Burial 2 ☐ Cremation 3 ☐ Removal from 3	otate	natory or other place)	Date	S S	c. Location - City <b>KESVILLE</b>	or Town, State
Baltimore,	t. Pa rtmen rtent: njury		4 Donation 5 Other (Specify)		w Cemetery		4 S	kyesvi	Lle, Md
Ba	Depriming Deposition of the police of the po		21. Signature of Funeral Service Licensee	( ) Ma	Name and Address of Fac arch F/H We	est			
ļ			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final	aused the death. Do not entach line.	194	as cardiac or re	spiratory arrest	,	21215 Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		Cardiova	Scular	Idise	use	years
13	Examiner		Due to	or as a consequence of):	+ Disease				1
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	or as a consequence of):					- ( 3000)
5	cuted	Examlner	Cause (Disease or injury that initiated events						
Ö	e exe ian a urial	I Ex	resulting in death) Last Due to (	or as a consequence of):					
58760,	icate be executed physician and s the burial-transit	dlcal	d						
-			IF FEMALE: 23c If yes out	come of pregnancy					
Box	The law requires that the death certifi ate has been signed by the attending t cage 2 should be detached for use as	Physician/M	in the past 12 months?	rth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
J.	that the de led by the a detached f	ysle	1 Yes 2 No 4 Pregn. 9 Unknown 9 Unknown		Gridi (specify)				
	res that igned b be deta	by Pt	Part II. Other significant conditions contributing to de	ath but not resulting in the ur	nderlying cause given in Par	t I.	23e. Did tobac	co use contribute	to the cause of death?
Hecords,	w require been sig should b	ed b	Value replacement surs	ery ~1/2004			1 🗌 Yes	2 🗆 🚻 3 🗆	Probably 4 Dunknown
ပ္က	awre is bec 2 sho	Completed		)			24a. Was an	24b. Were	autopsy findings available
	The law	Eo		-			autopsy performed 1 Yes 2 2	death	o completion of cause of ? es 2 LNo
<u>g</u>	ian: ntifica ctor, j	Bec	25. Was case referred to medical examiner?		26. Pla	ce of Death (C)			00 2000
<u> </u>	Physician: r this certifica ral director, j	2	- Hospital:	patient 2 R/Outpatien	t 3□ DOA Other: 4□ N	Nursing Home	5 🗆 Residenc	e 6 □Other (Sp	oecify)
ב	nding Physician: The la th. :: Atter this certificate has 9 funeral director, page 2		27. Mann of Death 1 □ atural 5 □ Pending (Month	f Injury 28b. Time of Injury	28c. Injury at Work?	28d.	Describe how i	injury occurred	
Sico	or Attending Ph after death. Director: After th in by the funeral	catl	2 Accident investigation		M 1 Yes 2				
Division of Vital	or Al	Certification:	determined 286. Place	of Inj <b>ury</b> - At home, farm, stre g, etc. <i>(Specify)</i>	et, factory, office	28f.	Location (Stree City or Town, S	t and Number or . itate)	Rural Route Number,
_	spital ours a neral filled		29a. Certifier 1□ Certifying Physician: To the	best of my knowledge, death	occurred at the time, date of	and place, and	due to the caus	e(s) and massa	as stated
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical	(Check only 2 Medical Examiner: On the ba	sis of examination and/or inv	restigation, in my opinion, de	eath occurred a	t the time, date	and place, and d	ue to the cause(s)
	To th within To the sompl	Me	29b. Signature and little of certifier	Den h	29c. License number	r	29d.	Date signed (Mo	nth, Dey, Year)
			1 Janu Ding	MY ME	1 D314	73	W	Lan 3.	2004
	5		30. Name and address of person who completed clus-	of death (Item 23a) (Type, I	Print)	. )		310	42
			PATTE A TOYE, N	10 4565 Hz	mock Con	12 W	KY, EI	Li WTTC	ity, MD
	Sta	te	31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature	- 11		*		

State of Maryland / Department of Health and Mental Hygiene 2 00 1 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:30 AM 5 04 Lee Henry /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bettys Place 1017 Wedgewood Rd Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Dete of Birth (Month, Oay, Year) 5-24-29 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 XM 2 ☐ F Baltimore, Md 217-24-4463 74 Director Usual Residence of Decedent within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State r than "naturel", or Items 23s or 28s-f show the Medical Esseriner must be notified at 1X Yes 2 No Completed by Funeral Director N/ABaltimore Md. 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 212072037 Featherbed Ln. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give<sup>2</sup> Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes X No Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Lumber Company Truck 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Charles Sophorinia Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beverly 2037 Featherbed Ln, Baltimore, Md, 21207 Bell Niece 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 5-6-04 Catonsville, Md. Metro Crematory \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

Lloyd M. Estep

Brothers Funeral Service Licensee

1300 Eutaw Place, Baltime

23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on such line. <sup>22. Name and Address of Facility</sup>
Estep Brothers FUneral Ser, P. A. 1300 Eutaw Place, Baltimore, Md. 21217 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Delen **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Munknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2 No 1 Yes To the hospines within 24 hours after death.

To the Funeral Director: After this certification in by the funeral director. Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) ASSISTED 1 ☐ Yes X No 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 🗍 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier 5 - 4 - 04of person Tr of death (Item 23a) (Type, Print) Reed Winston M.D. 3100 Towanda Ave, Baltimore, Maryland 21215 , Day, Year) 32. Registrar's Signature 31. Date filed (Mon State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			1 - For Amend Item 29	State o Od per Dr.,G	f Maryland 831 <b>,</b> 05/10/	/ Depa <b>/04d/ab</b> e	artment rtificate	of H	ealth a	and M	iental Hy	giene	004	148	54
	Physic		Decedent's Name (First, Middle	e, Last)	ne Enge						2. Date of Dea		Year	3. Time of D 2:10 a.	
>	/Medi Examir		4a. Facility Name (If not institution		nber)			Town, or	Location o		umbia		ty of Death	ward	
	Funeral Director		5. Social Security Number 157.56.7856 Usual Residence of Decedent	6. Sex 1 ☐ M 22 F	7. Age (In yrs. la 45	st birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) June 30	v, Year)	Cou	olace (State or intry) w Brunswic	
	th the Maryland or 286-f show	Director	10a. State 10b. County  Maryland  10e. Street and Number	Howard	10c. City,	Town or Lo	10f. Zip (		olumbia	3		10g. Citizen of		1 Od. Inside City 1 Yes 2	
036	d within 72 hours atter death with the Maryland Jiene. I then "natural", or Items 23e or 28e-1 show The Madical Examiner must be notified at	by Funeral	7279 Broken Timbe  11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dece	2 <b>₫</b> No e		Was Decede f Yes, speci 1 ☐ Yes 2		210 spanic Orig n, Mexican Specify:		ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	U.§ ice - Americack, White,	can Indian,	
Maryland 21215-0036	- E - B	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 17. Father's Name (First, Middle,	ct grade completed) College (1		(Give	dent's Usual kind of work DO NOT use	done di e retired) esearc	uring most ch scier	ntist		16b. Kind of I	rese		
rylanc	\$ 5 5 5	To Be		s George Eng	el	10b Mailin						rie Cairro	oco		
	ss 1 and 2 of Health is item 27 is other tre		Mr. John Lyon:  20a. Method of Disposition  1 □XBurial 2 □ Cremation	s Sp		7. ce of Dispos	279 Bro sition (Name natory or oth	ken Ti	imber V	Vay C	/ Route Numbe olumbia ate	20c. Location			
Baltimore,	permit. Page Department of Importent: If any injury or once.		*4 □Donation 5 □Other (S) 21 Signature of Furtheral Service I		Mola		hn's Ce Name and Sla	Address ack Fu	of Facility uneral h	dome.	P.A.		Ellicott C	ity, MD	
8760, 4	whedical physician and physician and the burial-transit in the burial-transit	dicai Examiner	23a. Part1. Ente the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aab	or as a conseque	nce of):	B A	of dying.	, such as c	ardiac o	r respiratory arr	est,	2101	Approximate Interval Betwe Onset and De	
.O. Box 6	death certiti e attending ad tor use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐No 9 ☐ Unknown	1 ☐ Live bi	ome of pregnance th 2 ☐ Fetal de ant at time of dead wn	eath 3 🗌	Ectopic pred						ate of delive	ry Day Yea	ar
ords, P	The law requires that the ate has been signed by the bage 2 should be detached.		Part II. Other significant conditio	ns contributing to de	ath but not resulti	ng in the un	derlying cau	use given	in Part I.			pacco use con es 2 No		e cause of deal	
Vital Record		e Completed	25. Was case referred to medical						OO Please		24a. Was a autops perform	ned?	Were autor prior to con death? 1  Yes	osy findings ava npletion of caus 2 No	allable se of
Division of Vi	ding Ph h. After th funeral	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date o (Month		VOutpatient Bb. Time of Injury		Other: c. Injury a Work?	4 ☐ Nurs	sing Hom	Check only on e 5 K Reside 3d. Describe ho	nce 6 Oth		)	
DIX	To the Hospitel or Atten within 24 hours after deatl To the Funerel Director: completely tilled in by the		3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of buildin	of Injury - At home g, etc. (Specify)						3f. Location (St. City or Town	, State)			r,
	To the Hospitel within 24 hours a To the Funerel I completely tilled	Medical	29a. Certifier (Check only one)  2 Medical E  29b. Signature and title of certifier	y Physicien: To the la xaminer: On the ba and mann	sis of examination	edge, death n and/or invi	estigation, ir	the time n my opir License r	nion, death	place, ar occurre	d at the time, da	ate and place,	and due to	the cause(s)	
	F 3 K 8		> Inf-	~ ~	and describe #1	201/7			320		25	Od. Date signe		04/30/20	004
	Sta Registra		30. Name and address of person v	TTING		075	E-	a LL	5 A	.8.	hoth	-naich	+ 40	2109	13.

			1 - State Registrar	State of Maryl	and / Depa		lealth and	Mental Hyg	g. No. 200	
-	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  ROBERT E L  4e. Fecility Name (If not institution, give si		>	4b. City, Town, or	Location of Deal	2. Date of Deat Month MA	Day Yea  5 200 L  4c. County of De	+ 5:101.W.
	Funeral Director		GOOD SAMARITAN He 5. Social Security Number 6. Sex	OSPITAL	rrs. last birthday) Yrs.		ORE CITY  If Under 24 Hrs  Hours Min.		N/A	irthplace (Stete or Foreign Country)
		ctor	Usual Residence of Decedent  10a. State 10b. County  MD BALTIMOI	10c.	City, Town or Lo			1 /(2/21	9JO   MA	RYLAND  10d. Inside City Limits  1 □ Yes 2 ☒ No
96	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 show the Medical Exercities the registred at	by Funeral Director	1 ☐ Never Married 2 ☑ Married	2. Was Decedent Ever in Armed Forces?  1 ☑ Yes 2 ☐ No If Yes, Give		10f. Zip Code  2123  Was Decedent of Hir f Yes, specify Cubar  1 Yes 2 X No	spanic Origin? (S n, Mexican, Puer		USA  14. Race - An Black, Wh	nerican Indian,
21215-0036		Completed by	3 Widowed 4 Divorced  15. Decedent's Educi (Specify only highest grade  Elementary/Secondary (0-12)  12TH GRADE	ation	16a. Deced (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired)	ation	rking	Specify:  16b. Kind of Busines  SELF EMPL	
Maryland	0 0 0	To Be (	<ol> <li>Father's Name (First, Middle, Last)</li> <li>WILLIAM T. LIBSCOI</li> <li>Informant's Name/Relationship (Type)</li> </ol>		19b. Mailir		ANNA H		feiden Sumame)  City or Town, State,	Zip Code)
Baltimore, M.	Pages 1 and 2 should nent of Health and Mer ant: If item 27 is marks ury or other traumatic		CAROLE A. LIPSCOMB  20a. Method of Disposition  1\$\overline{\Pi}\$ Burial 2 \( \text{Cremation} \) 3 \( \text{Re} \)  4 \( \text{Donation} \) 5 \( \text{Other} \( (Specify) \)	mayal from Ctata	D. Place of Dispo	DARRICH I sition (Name of natory or other place CEMETERY	1		MD 2123 Oc. Location - City of ALTIMORE,	r Town, Stete
Balti	permit. Pages Department of Important: If i		21. Signature of Funeral Service Licensee		85	21 LOCH F	s of FaciliTHE RAVEN BL	JOHNSON VD. TOWSO	FUNERAL H	OME, P.A. 286
760,	Physician   Medical Examiner   Medical Examiner   Physician and street   Physician and stre	cal Examiner	23% Part. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last		sequence of):	or the mode of dying	, such as calliar	от теариацију атте	SI,	Approximate Interval Between Onset and Death
.O. Box 687	that the death certificate ted by the attending physic detached for use as the b	Physiclan/Medlo	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of preduction of the control of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
0_	The law requires that ate has been signed b page 2 should be deta	by	Part II. Other significant conditions contr	ributing to death but not r	resulting in the un	derlying cause giver	n in Part I.	11		o the cause of death?
Vital Records,	ician: The law certificate has b ector, page 2 sl	Be Completed	25. Was case referred to medical				26 Place of Dea	24a. Was an autopsy performe 1 Yes at	prior to death?	utopsy findings available completion of cause of
ot	tending Physicath.  tor: After this the funeral dir	Certification: To B	examiner?  Yes 2 No Ho.  27. Manner of Death  Polyatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	spital: 1  Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spe	home, farm, stre	3 DOA Other 28c. Injury a Work? M 1 Ye	4 Nursing H	ome 5 Residen 28d. Describe how	ce 6 Other (Sperinjury occurred	
	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	Medical C	29b. Signature and title of certifier	cian: To the best of my k	nowledge, death nation and/or inv	29c. License	nion, death occur number	red at the time, date	e and place, and due  1. Date signed (Mont	to the cause(s)
Ĺ	++1		30. Name and address of person who com KALATHIL Sti 31. Date filed (Month, Day, Year)	pleted cause of death (It			(823) SAMAR	TAN HI	PATIFICAL,	2004 Mg 21239
	Sta Registra		MAY 1 n 2004	32. Registrar's Sig	riature					

			For State Registrar	Type or Prin State of Ma		Оера		Health and			e 2001	+ 148	
	Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Yee								2004	3. Time of Dea	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  IVY Hall Geriatric Center				4b. City, Town, or Location of Death Middle River			4	4c. County of Death Baltimore		
	uneral irector		5. Social Security Number 6. So 234 36 9930 1		e (In yrs. last bir 19	rthday) Yrs.	If Under 1 Year Months Days			irth ay, yea , 192	rı Co	thplace (State or For ountry) ginia	
anyland	iene. r than "netural", or Itams 23a or 28a-f ahow the Medical Examinat must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Manual and Daltimo	<b>7</b> 0	10c. City, Town or Location ESSEX								
the M			Maryland Baltimo	re	LS	10f. Zip Code			10g. C	Citizen of What Co	1 ☐ Yes 2₺ ountry?		
h with			1514 Strawflower	D'' 21221					USA				
72 hours after death with the Maryland			11. Marital Status  1 ☐ Never Married 2 ☐ Marned  3 ☒ Widowed 4 ☐ Divorced	Ever in U.S.	er in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 XNo Specify:				o- 14. Race - American Indian, Black, White, etc.  Specify: White				
72 ha			15. Decedent's Ed (Specify only highest gra	16a	16a. Decedent's Usual Occupation (Give kind of work done during most of working					b. Kind of Business/Industry			
within	than he Man		Elementary/Secondary (0-12) College (1-4or 5+)  11  College (1-4or 5+)  Manager							Computers			
be filled	atal Hyg		17. Father's Name (First, Middle, Last)  Joseph Olivito  18. Mother's Name (First, Middle, Maiden Mary Borilla						зитате)				
S	item 27 te marke other traumatic	۲	19a. Informant's Name/Relationship (7	ype, Print)	196	. Mailir	ng Address (Stree	at and Number or R	ural Route Num	ber, City	or Town, State, 2	Zip Code)	
and 2	tem 27 l			(Nephew)				gomery St		-			
Pages	Department of He Important: If iten any injury or oth once.		20a. Method of Disposition  1		cemete	ry, crer	sition (Name of natory or other pl 1 Mem. (	Gardens 5,	7/2004		Location - City or Ltimore,	Maryland	
permit.	mport mport iny inj		21. Signature of Juneral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221										
			23a. Part Enter the disease, or comp	DUTAGE plications that caused	the death. Do	not ent	er the mode of dy	Eastern ing, such as cardia	AVENUE I	LISSE arrest,	x, Ma. 2	Approximate Interval Between	
\N	ysician Iedical aminer		23a. Panf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):							Onset and Death			
be executed	hysician and the burial-transit	lical Examiner	Securately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):										
he death certificate	fler death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year					
luires that		Completed by PI								o use contribute to the cause of death?			
The law requires that the			Rospirat	ory:	Indus	H	Chenc	1,	per	opsy formed?	death?	utopsy findings avail completion of cause	
		0	25. Was case referred to medical	V			<i></i>	26. Place of De	1 ☐ Yes ath (Check only	2⊠ N one)	10 10 103	2 140	
Physician:		ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify)							city)		
DG .		Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and A							un l Pouto Alumbo		
ō:			4  Homicide determined	building, etc	c. (Specify)	City or Town,					te)		
Hosp	Fune Fune	dica	29a. Certifier (Check only one)  12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  12 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated.										
To the	within 24 hours a  To the Funerel t  completely filled	Med	29b. Signature and title of certifier					29d. D	MAY G 2004				
1	0		30. Name and address of person who	completed cause of d				., BA	LTIM	ORE		0.2122	
		_ 1	31. Date filed (Month, Day, Year)	~ !!				, ,-,,		_	. 'V (		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2015e 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death hns Hopkins Bayview Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 7, 6. Sex 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) Days 1 M 2/5/F Yrs 218-01-6442 Maryland 84 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Maryland 1 ☐ Yes 2(XNo Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 2326 Poplar Road U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ferdinand Kutilek Johanna Polisny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Georgia McDonough (Daughter) 12 Horney Court, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Of Jesus May 8,2004 Baltimor, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licenses 22. Name and Address of Facility
Eruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death or heart failure. List only one cause on Immediate Cause (Final diseate or condition resulting in death) CERTIFI APPROVED BY MENOAL WINEF 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) e underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No

**Physician** /Medical **Examiner** 

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After

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within 24 hours after death To the Funerel Director:

The law requires that the

Attanding Physician:

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To the Hospital

P.O. Box 68760,

Division of Vital Records.

any

**Physician** 

/Medical

Director

Funeral

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Completed

Be

Examiner

**Funeral** 

Director

ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Exercities must be notified at

Il Hygiene.

permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked o

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

as the burial-transit use detached 90 Complete page Be Certification: To funeral dir the completely filled in by

miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):
dical Exa	resulting in death) Last	Due to (or as a consequence of):
d by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death  9 Unknown
d by Ph	Part II. Other significant condition	ns contributing to death but not resulting in the

Other 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

April 25, 2004 1 ☐ Yes 2 ☐ No 1400 Place of Injury - At home, farm, street, factory, office building, et. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2326 Poplar

(Check only 29b. Signature and title of certifier

1 0 2004

5 Pending

investigation

6 Could not be determined

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one

RES-000

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Eastern Avenue, Baltimure, MD2122

30. Name and address of rson who completed cause of death (Item 23a) (Type, Print) GALL 31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

1 Pres 2 No

27. Manner of Death

1 □Natural 2 □ Accident

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month **Physician** 6, 11:50 AM Carmillia E. Mendoza May /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month Pay. Year! 43 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** 1 M 2 F Maryland 219-92-5579 61 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f show the Modical Exemples must be notified at 1MYes 2 No Director Maryland Baltimore the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1404 Anglesea Street Apt. 1D 21224 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Rece - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than amy rigury or other traumatic event. In M. ADGE. Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charlotte Schultze Walter Langley မ 19a\_Informant's Name/Relationship (Type, Print) Ethel Jean Josephina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Anglesea St. Apt 1D Baltimore, MD 21224 Mendoza --20a. Method of Disposition Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery 5/11/2004Baltimore.Maryland 21. Sgnature of Funeral Servi 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 21231 Pert1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. 401 S. Chester St. Baltimore, Maryland enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final disease or condition 10 years Heart Disease Physician oronaly resulting in death) /Medical Due to (or as a consequence of): Examiner Lerosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō 5 Other (specify) ached f 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Mull 2 No 1 Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s certificate has firector, page 2 autopsy performer 1 ☐ Yes 2 ☐ No 1 Yes 2 € or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 / Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this Alter thi 28a. Pate of Injury (Month, Day Year) 27. Manner of Feath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funerel Director: completely tilled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0033897 ZIUND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Bastern 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar .0

**ORIGINAL** 

Division of Vital Records, P.O. Box 68760, othe Hospitel or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

N. D		State     Registrar  1. Decedent's Name (First, Mide	dle Last)		Ce	rtificate of	Death	2. Date of Dea	Reg. No.	200	3. Time of Death		
Physicia /Medica		Month Day Year											
Examine		4a. Facility Name (If not instituti	on, give street and nu	mber)	1 (2.4		or Location of Death	4c. County of Death					
		Johns Hopkins Bayview Medical 5. Social Security Number 6. Sex 7. Age (In yrs.			rs. last birthday				07/06	706/38 9 Birtholago (State or E			
Funeral Director		1 kg M 2 □ F							rthplace (State or Foreign Sountry) rth Carolina				
yland		10a. State 10b. Count	у	10c.	City, Town or L	ocation					10d. Inside City Limits		
Be-f el	Director	MD	N/A		Baltim	ore					1X Yes 2 No		
death with the Maryland ms 23e or 28e-f ehow friust be notified at		10e. Street and Number				10f. Zip Code				en of What C	country?		
ns 23	Funeral	223 North Mil 11 Marital Status	12. Was Dec	edent Ever in	n U.S. 13.	212 Was Decedent of H If Yes, specify Cub		pecify Yes or No-		J.S.A. I. Race - Am	erican Indian,		
urs after	۵	1 ☐ Never Married 2X Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Gi	2 🗆 No		If Yes, specify Cub  1 ☐ Yes 2 ☑ No	Specify:	o Rican, etc.)		Black, Wh	•		
in 72 ho	Completed	(Specify only high	est grade completed)		(Give	edent's Usual Occup kind of work done DO NOT use retire	during most of wor.	king	16b. Kind	of Busines	s/Industry		
d with giene.	E	Elementary/Secondary (0-12)	College (	1-40r 5+}	Mach	ine Opera	tor		Life	Like	Products		
be file d oth event	Be	17. Father's Name (First, Middle	, Last)				18. Mother's Nan	ne (First, Middle.	Maiden S	Sumame)			
should and Men s marke umatic	0	James McDouga  19a. Informant's Name/Relation			10h Mail	ing Address (Street	Joann N		c City or	Town State	Zin Codo)		
and 2 shalth an n 27 is reur		Porsha Ransom	isinp (Type, Filit)			-					land 21224		
of Hea		20a. Method of Disposition	2		b. Place of Disp	osition (Name of matory or other pla	I	Date			r Town, State		
Pages ment of ent: If It ury or o		1 ☑ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other		State	Loudon	Park	5/1	12/04			, Maryland		
Depart Depart Import any in		21. Signiture of Funeral Service Licensee  22. Name and Address of Facility Charles S. Zeiler & Son, Inc.  6224 Eastern Avenue Baltimore, Maryland 21224											
		23a. Part1. Enter the disease, shock or heart failure. Li	or complications that only one cause on	caused the deach line.	eath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition resulting in death)	a Disso	minak	d Intra	vuscular	Coaguin	hon			Onset and Death MINUTES		
/Medical Examiner		Due to (or as a consequence of):											
4	Jer	Sequentially list conditions, b											
executed in and ial-transii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	) c										
bour pour	_	Tosaking in Goatily Last		(or as a cons	sequence of):								
ficate g phys	edic		d										
eath certificate be executed attending physician and for use as the buriat-transit	M/M	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			⊒Ectopic pregnancy	ı		23	d. Date of de	,		
that the deal ed by the att detached for	Physician/Medical	in the past 12 months?  1  Yes 2 No 9  Unknown  1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)							Month Day Year				
es the	2	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hyper tension, Diahetes, pancreatitis						23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown					
w requi	Completed							24a. Was a					
ha he	E							autop	sy med? 2√X No	prior to death? 1 ☐ Ye	24		
ician: Th	Bec	25. Was case referred to medical syaminer?  26. Place of Death (Check only one)											
Attending Physician: sr death. ector: After this certific by the funeral director.	0	Pospital: 1 Delinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other									ecify)		
ding I th. After funer	i on	27. Manner of Death  1 Naturat 5 ☐ Pend 2 ☐ Accident inves		oth, Day Year	28b. Time of Injury	Wor	yat rk? Yes 2 □ No	28d. Describe n	ow injury	occurred			
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ertification:	3 ☐ Suicide 6 ☐ Coul	not be 28e. Place	e of Injury - A ing, etc. (Spe	at home, farm, st	reet, factory, office		28f. Location (S City or Tow		Number or F	lural Route Number,		
Hospitel 24 hours Funerel tety filled	edical C	29a. Certifier (Check only one) Certify	ing Physician: To the	e best of my loasis of examiner stated.	knowledge, deal	th occurred at the time	ne, date and place ppinion, death occur	, and due to the c	ause(s) a	nd manner a lace, and du	s stated. e to the cause(s)		
ro the vithin ?	Me	29b. Signature and title of certif				29c. Licens	se number	2	29d. Date	signed (Mon	th, Day, Year)		
IX,		► Val 16851 May,							118,2	004			
K'		30. Name and address of person Vuleviani R.	hora cl	se of death (I	Item 23a) (Type O Guste	Print) vn Avenv	e Baltin	ine Mo	2122	24			
Stat Registra		31. Date filed (Month, Day, Yea		Registrar's Sig	gnature	boules		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND TIEM #1 PER PHY G831 5/10/04 CHErtificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JON ANTHONY **Physician** Year 2004 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death, 4c. County of Death Examiner ANNAGOLIS

If Under 1 Year If Under 24 Hrs. 8.

Months Days Home ticks VENUE 7. Age (In yrs last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 216-74 100M 20 F Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Annapolis Hnne **Funeral Director** MD 1 ☐Yes 2 ☐Ho 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 140 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Black 5 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Viechanic Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) R. matthews and Merital Marshall Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Health mportant: If item 27 other 20a. Method of Disposition

1 Burial 2 Dicremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 70 ā 3 Removal from State Zon Cemeter ' 4 ☐ Donation S ☐ Other (Specify) injury 21. Signature of uneral Service License 22 Name and Address of Facility H270 Fredhilton es bolto, mid alaag 23a. Paint Enter the disease, or complications that caused the death. Do not enter the mode of dying, show, it has failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest Immediate ause (Final disease) a condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical examiner?
1 12 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification; 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier Deputy 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

			for State			/ Departme	ent of Health an	-		
			Registrar  1. Decedent's Name (First, Middle, La	st)		Certifica	lle oi Dealii	2. Date of D		3. Time of pelmp
	Physici /Medio		MARY	А	GNES	M	ONEN	Month	Day Year	4 500 AM
	Examir		4a. Facility Name (If not institution, giv	e street and number)	D 14	4b. Cit	y, Town or Location of D		4c. County of De	
			5. Social Security Number	iex 7. Age	e (In yrs. las	t birthday) If Und	ler 1 Year   If Under 24	Hrs. 8. Date of B	irth 9.8i	N/A
	Funeral Director			□M 2∏F	72	Yrs. Month		Min. Month, E MAY 2	13, 1931	rthplace (State or Foreign country) NY
\	death with the Maryland ms 23a or 28a-f show f nast be ricilised at	2	10a. State 10b. County		10c. City, T	Town or Location	_			10d. Inside City Limits 1   Yes 2   No
7	the Marylan 28a-f show	Funeral Director	MD N/A			BALTIMOR	L Zip Code		10g. Citizen of What C	
	3a or	D	17 HAMILL ROAD #0	2		101.2	21210		rog. Onizon of What C	U.S.A.
3	ems 2	Inera	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Dec	cedent of Hispanic Origin becify Cuban, Mexican, P	(Specify Yes or Nuerto Rican, etc.)	lo- 14. Race - Am Black, Wh	erican Indian,
Mary 121215-0036	within 72 hours after death wene. then "natural", or Items 23a the Medical Examiner must t	Completed by Fu	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 □ Yes 2 💢 N If Yes, Give Year or Dates:		1 ☐ Yes	2 No Specify:		Specify:	WHITE
Mary 21215-00	n 72 t	lete	15. Decedent's Ed (Specify only highest gra	ide completed)		16a. Decedent's Us (Give kind of s life. DO NOT	sual Occupation work done during most of use retired)	working	16b. Kind of Business	s/Industry
₹ 212	e filed within al Hygiene. other then vent, the Me	omo	Elementary/Secondary (0-12)	College (1-4or 5	i+)	SALESLAD			TALBOTS	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-1 show other treumetic event, the Medical Examinating that be notified at	To Be C	17. Father's Name (First, Middle, Last, UNKNOWN)			GLECKNER		Name (First, Middl	e, Maiden Sumame) (UNKNOWN)	
Jan	2 sho	ġ.	19a. Informant's Name/Relationship (				ess (Street and Number o		-	
	os 1 and 2 of Health of Item 27 I		SIDNEY MONEN / HU 20a. Method of Disposition	JSBAND	20b. Plac	I / HAMIL  e of Disposition (Netery, crematory of	L ROAD #C -	BALIIMUR	E, MD Z1Z10	
nor	ages ent of nt: If It		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif				1	/7/2004	OWINGS MI	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any Inlury or ot once.		21. Sign your of Funeral Service Lice	11	PID V				SON & BROS.	
ä	Dermi Depa Impo any It		1/1 Miller	This	vaca		REISTERSTOW	N ROAD -	PIKESVILLE,	
	Physician		Sa. Part 1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lir	the death.	Do not enter the m	ode of dying, such as car	diac or respiratory	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or s	a consequer					\ \
1	504	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequer	cancer of):				1 year
00 V	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	C.						
, O	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequer	nce of):				
8760	cate b ohysic the b	dlcal	•	d						
89 x	certifi Iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	y			23d. Date of de	liveo
P.O. Box	Attending Physicien: The law requires that the death certifica r death. r death. ector: Afler this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	by Physician/Med	in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown	1□Live birth 4□Pregnant at 9□Unknown					Month	Day Year
	w requires that been signed I should be det	ed by P	Part II. Other significant conditions of	ontributing to death be	ut not resultir	ng in the underlying	cause given in Part I.		tobacco use contribute to	o the cause of death?
ဝိ	e law requ has been je 2 shouli	Completed						24a. Wa		utopsy findings available completion of cause of
<u>~</u>	The tate has page	Com						peri 1 ☐ Yes	ormed? death?	s ELINO
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	Death (Check only		
o	ding Physicien:  After this certific funeral director,	.: To	1 ☐ Yes 2 ☐ No 27. Mann of Death	28a, Date of Injur	ry 28	VOutpatient 3☐ 0 Bb. Time of	28c. Injury at		how injury occurred	ecify)
ion	nding F ath. r: After e funer.	atior	1 X atural 5 ☐ Pending 2 Accident investigation	(Month, Day	Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	el or Attendi s after death of Director: A	Certification:	3 Suicide 6 Could not be determined		ury - At home c. (Specify)	e, farm, street, fact	ory, office	28f. Location City or To	(Street and Number or F own, State)	ural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (	29a. Certifier Check only one) Certifying Ph	ysicien: To the best of miner: On the basis of and manner sta	examination	edge, death occurre n and/or investigation	ed at the time, date and ploon, in my opinion, death o	ace, and due to the courred at the time	cause(s) and manner a , date and place, and du	s stated. e to the cause(s)
	To til To til comp	Ň	29b. Signature and little of certifier	//		2	29c. License number		29d Date signed (Mon	th, Day, Year)
									5	,2004
	10		30. Name and address of person who	11/10	eath (Itèm 23	3a) (Type, Print)	Smai Hor	mal of	Baltmore	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 0 2004	32. Registra	ar's Signatur	book.				

			1 = For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>	ealth and Death	Mental Hygi	iene 2001	14862
	Dhusisi		1. Decedent's Name (First, Middle, La	st)					2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		Virginia Mae			ssle	1		May	5, 2004	11:20 P M
F.	Examin	er	4a. Facility Name (If not institution, giv		imber)		4b. City, Town, or Ellicot		th	4c. County of Dea	_
	Funeral		5. Social Security Number 6. S		7. Age (In	yrs. last birthday	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		
	Funeral Director			□M 2MTF		Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, Jan 24,	Year) Co 1915 V	thplece (State or Foreign ountry) irginia
	pu ,		Usual Residence of Decedent		1 10	Ch. T.					
	ehov	ō	10a. State 10b. County  Maryland Howard		100	c. City, Town or Le ביווים	icott City				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the h	rect	Maryland Howard  10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	
	3a or	i Di	2901 Evergreen Wa	ıy			210	)42		_	ited States
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow na Medical Examinar must be notified at	Funerai Director	11. Marital Status	12. Was Dec	edent Ever	in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (	Specify Yes or No-	14. Race - Ame Black, Whit	
36	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, G	2 X No ive		1 ☐ Yes 2 ☑ No	Specify:	to riioari, oto.,		hite
21215-0036	hours tural'	ed by	3 XWidowed 4 ☐ Divorced  15. Decedent's Ed	Year or I	Dates:		dent's Usual Occupa	tion	1		
15	n na	Completed	(Specify only highest gra	de completed,		(Give	kind of work done a  DO NOT use retired,	uring most of wo	orking '	6b. Kind of Business	industry
212	d with giene er tha	mo	6	College	(1-4or 5+)	Hor	nemaker			Own	. Home
nd	sal Hy d oth	Be (	17. Father's Name (First, Middle, Last,						me (First, Middle, M		
yla	Ment Ment Marke Marke	ဥ	John Thomas Rile	•					Sevina L		
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship ( Jacqueline Auld /		tor					City or Town, State, 2 ity, Maryl	
	1 and Healt am 2		20a. Method of Disposition	Daugii		Ob. Place of Dispo	sition (Name of			Oc. Location - City or	
<u>o</u> E	ages ent of nt: If II		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specif		State	cemetery, cre	matory or other place age Mem. I			Elkridge,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Iteme 23s or 28s-1 ehow eny injury or other traumatic event, the Medical Examiner must be rediffied at once.		21. Signature of Funeral Service Licer		V	22	2. Name and Addres	s of Facility	Hubbard F	uneral Hom	
	- N		23a. Part1. Enter the disease, or com	olications that	caused the						Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.		ACCIDE				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a		nsequence of):	74001				2wlcs
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	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to	(or as a co	isaquence of).					
	and and Il-tran	хаш	that initiated events resulting in death) Last	c	(or as a co	nsequence of):					
68760,	icate be executed physician and the burial-transit	dical		d	,	,.					
687	ificate g phy as the	edic		d							>
Вох	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pr		Ectopic pregnancy			23d. Date of deli	
	at the death by the attentached for	sicia	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nant at time		Other (specify)			Month	Day Year
P.0	hat th ad by I	Phy	Part II. Other significant conditions of	ontributing to c	leath but no	t resulting in the u	nderhving cause gwe	n in Part I	23e Did tob	acco use contribute to	the cause of death?
ds,	signed t	d by	Taken and a grand and a second and a	Sittle Gtarg to C	odiii bai iio	rrosuling in the c	ilderlyllig cadse give	THE CALLS.			obably 4 Unknown
Vital Record	w requir been si should	Completed				-			24a. Was an		topsy findings available
Be	The lav	дшо							autopsy perform	ed? prior to death?	completion of cause of
tal		0	25. Was case referred to medical					26 Place of De.	1 ☐ Yes 2 ath Check on one	No 1 □ Yes	2□ No
	9 %	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆	Inpatient	2 ER/Outpatier	nt 3 DOA Othe			ce 6 ☐Other (Spec	cify)
o uo	After fune		27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation		of Injury oth, Day Yea	28b. Time of Injury	28c, Injury Work	at	28d. Describe how		
Division of	l or Atte after dea Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	288. Place	e of Injury - ing, etc. (S	At home, farm, str oecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edicai C	29a. Certifier (Check only one)	iner: On the b	e best of my easis of examiner stated.	knowledge, deat mination and/or in	n occurred at the time vestigation, in my op	e, date and place inion, death occu	e, and due to the cau arred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifie	0			29c. License			d. Date signed (Month	
	-		> Ell UE	our			234	451	1	Day 6, 2	004
	10		30. Name and address of person who	completed cau	se of death	(Item 23a) (Type,	Breder C	Re du	Je 100 (	Cotnorll.	mD 21228
	Sta	te	31. Date filed (Month, Dey, Year) MAY 1 0 200		Registrar's S						
	Registra	-11	- U LUU	T July 1	Call S	A A A A A A A A A A A A A A A A A A A	act D				

				1- State of Maryla Registrar	and / Depa	rtment of Health a tificate of Death	nd Mental Hyg	giene 2001 Reg. No.	+ 14863
		Physic /Medi	cal	Decedent's Name (First, Middle, Last)     ALFRED		NATHANSON	2. Date of Dea Month May	Day Yeer	/ / //
		Examir Funeral	ner	4a. Facility Name (If not institution, give street and number)  LEVINDALE  5. Social Security Number  6. Sex  7. Age (In yi	rs. last birthday)	4b. City, Town, or Location of BALTIMORE  If Under 1 Year If Under 2	4 Hrs. 8. Date of Birth	4c. County of Dec	
	N.O.	Director		216-12-8705	2 Yrs.	Months Days Hours			rthplace (State or Foreign ountry) RYLAND
		the Maryla 28a-f sho	rector	MD N/A		I MORE		log. Citizen of What C	10d. Inside City Limits 1 X Yes 2 □ No
		death with Ims 23a or	Funeral Director	2434 W. BELVEDERE AVE.	U.S. 13. W	21215 /as Decedent of Hispanic Origin Yes, specify Cuban, Mexican,		USA 14. Race - Am	
	9600	hours after ural', or its	d by Fu	A med Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2 X No Specify:	Puerto Rican, etc.)	Black, Whi	te, etc. VHITE 
	Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or itams 23a or 28a-1 show other traumatic event, it's Madical Exeminer must be rediffed at	Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12	life. D	ent's Usual Occupation ind of work done during most o O NOT use retired) DWNER	of working	16b. Kind of Business CLOTHING 8	·
	land	ild be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last)  SAMUEL RICHARD	NATHANSO	18. Mother's	s Name (First, Middle, I		
	, Mary	and 2 shouseith and No. 27 is mai		19a. Informant's Name/Relationship (Type, Print)  JAMIE MILLER (DAU.)	19b. Mailing	Address (Street and Number	or Rural Route Number		
	Baltimore,	permit. Peges 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra once.		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)	. Place of Disposi cemetery, crema	ition (Name of atory or other place)	Date	20c. Location - City or REISTERST(	
	Ball	Departi Depart Import eny in		21. Signature of Funeral Servicy Livensee	80	Name and Address of Facility  OO REISTERSTO	SOL LEVINS	ON & BROS.	,INC.
•		Physician /Medical		23a. Part1. Enter the disease, or complications that caused the deshock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		the mode of dying, such as ca	rdiac or respiratory arre	est,	Approximate Interval Between Onset and Death
N		Examiner	er	Sequentially list conditions, if any leading to immediate					
028		eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	cause. Enter underlying Cause (Disease or injury that inflated events resulting in death) Last  C.  Due to (or as a conse	equence of):				
ALFI	P.O. Box 68	Attending Physician: The law requires that the death certificar death.  sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregions to the pregnant at time of	tal death 3 □E	ictopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
2	rds, P	quires that n signed b ud be deta	d by Pł	Part II. Other significant conditions contributing to death but not re	sulting in the und	erlying cause given in Part I.	i	acco use contribute to	the cause of death?
4NSON	Vital Records,	: The law requir cate has been si page 2 should	Completed	normal Pressure 1ty	drace	plalus	24a. Was ar autopsy perform 1  Yes 2	prior to death?	topsy findings available completion of cause of
44	of Vita	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatient	0.1	Death (Check only one	9)	-
17 7	Division of	Attending F death. ctor: After y the funera	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28b. Time of Injury	28c. Injury at Work?  M 1 Tyes 2 No	28d. Describe ho		
5	Div	To the Hospitel or Attendir within 24 hours after death.  To the Funerel Director: At completely filled in by the fu	al Certif	4 Homicide  29a. Certifier  Certifying Physician: To the best of my kn	cify)		City or Town.		
_	4	To the Howithin 24 h To the Fur completely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	ation and/or inves	29c. License number	occurred at the time, da	te and place, and due  d. Date signed (Month	to the cause(s)
	,	n		30. Name as address of person who completed cause of death (Ite	em 23a) (Tvna Pr	056508	SHAD	may 5	2004
		3 Stat	te		ive,	Baltimore	MD		
	, inje	Registra		T 0 2004	S Again				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Richard retta way mai 6, 9004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial MEdical Center Balto 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign **Funeral** 1 € M 2 □ F Days Hours MARY Director Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rtment of Health and Mental Hygiene. rtent: If item 27 is marked other than "natural", or Items 23a or 28e-f shov njury or other treumatic event, <u>The Medical Extrafror must be notified at</u> 28e-f show Baltimore 1 Yes 2 No Md Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: BLack 1 🗆 Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Vendor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto. Md. sister 15 &1 Collington Ave 00511 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lansdowne, MD. 104 ortent: I Zion Cemetery \* 4 □ Donationy 5 □ Other (Specify) permit.
Deportmit.
Importe
any nju Metropolitic chapel 21. Signature of Coneral Service Licensee 22. Name and Address of Facility | Miller? 1639 N. BROADWay Balto. MO. 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or asia consequence of): da /Medical 5 days Examiner rneumonic Sequentially list conditions, if any, leading to immediate cause that Indexty graves (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physicien a Division of Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has b lirector, page 2 st autopsy performed? 21X/No 1 Yes 1 Yes this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 SInpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Injury at Work? After t Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the f 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

Registrar

State

201 East University Parkway

Baltimore, MD 21218-2895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Chelsia Varner

MAY 1 0 2004

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O3 Month Year **Physician** 4:33 P.M Robert Vincent Pletzer, Sr. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AGNES HEALTHCARE n/a 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Hours Days 1**X**M 2□ F Months 218-42-7817 59 Director March 2 1945 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f ehow traumatic evant, the Madical Examinar must be notified at 1 X Yes 2 No Directo Maryland n/a Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1003 DeSoto Road United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 1 and 2 should be filed within Health and Mental Hygiene. em 27 le marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Bottling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Lam Kenneth Pletzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ant: If item 27 le David Dell / Friend 1003 DeSoto Road, Baltimore, Maryland 21223 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) injury or Department of Important: If any injury or once. Meadowridge Mem. Park 5/7/2004 Elkridge, Maryland 21. Signatury of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List poly one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** of Unknown Primary Origin Metastatic Un Known /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 R/Outpatient 3 DOA 1 Inpatient this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) your 1205584 May 03 2004 30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

MAY 1 0 2004

South

ergesm

33. Registrar's Signature

Hospital goucaton here Baltimore

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Amend ITen#1 1- State Unpend ITen#23a, Part II, 27, 28a-f, PFR ME 1834 5 26/Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year RHODES, JR. BURNIE LEROY APRIL 14, 9:58 P M 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MERCY MEDICAL CENTER BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 3, 1949 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours M 2□F Vre 214 50 5997 54 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ahow other traumatic avent, the Medical Examinar must be notified at BALTIMORE 1 Yes 2 □ No N/A Director MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2415 McELDERY STREET 21205 U.S. OF A. 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 1 ☐ Yes 2 ☐ No Specif BLACK Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH UNKNOWN COOK RESTAURANTS other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permi. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic avent 9062. Be ( BURNIE LEROY RHODES, SR. DORETHA ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORETHA RHODES (MOTHER) 2415 Mc ELDERY STREET BALTIMORE, MD. 20b. Place of Disposition (Name of 20a. Method of Disposition 4/23704 VET. CEM. 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) GÁRRTSÖN"FÖREST OWINGS MILLS, MD. 21. Signature of Funeral Service Licenses EEWIS Tress GWYNN FUNERAL HOME 21215-6393 GWYNN nn 4517 PARK HEIGHTS AVENUE BALTO., MD. Part1. Enter the disease, or complications that caus dithe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Actite Alcohol Intoxication resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Chronic Alcoholism 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 □ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 💆 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To XXYes 2 No

The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, Attending Physician: s after de....al Director: Altr filled in by ŏ within 24 hours a To the Funeral C

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 K Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) found 4/14/04 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found on porch

28b. Time of Injury found 6:000

28c. Injury at Work?

28d. Describe how injury occurred unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State) 400 blk. N. Montford Avenue Baltimore 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number OCME 29d. Date signed (Month, Day, Year) APRIL 15, 2004

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

eenberg \$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2001 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician Alexander Joseph Schultz 2:201 la /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health Baltimore Carel DainT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) ocial Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months MOXM 2 F 220-24-1120 75 Director 10, 1928 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 7 is marked other than "neturel", or frams 23s or 28e-f shov treumatic event, the Madical Expr. inust be notified at 1 Yes 2 No Director Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5901 Grace Lee Avenue 21784 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: þ Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) agas 1 and 2 should be fill of of Health and Mental History 27 Is marked oth Be ဂ္ William Schultz Mildred Jean Schultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5901 Grace Lee Avenue Mildred Jean Schultz - Wife Sykesville, Maryland 21784 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State Ь Other (Specify) 4 Donation Meadowridge Mem. Park | 5/11/04 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral 7250 Washington Blvd. 21. Signature of Fu era Service Licensee any l Home At MMP., Inc. Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final interction Physician Myourdha UN Kn sun disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician Physiclan/Medical the IF FEMALE: 980 If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 3 No Vital 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ٥ 2 ER/Outpatient 3 DOA Division of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital or At thin 24 hours after d the Funerel Direct 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ္က W 147353 2004 ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Bultimore, Mary 900 Caton Avenue

DHMH 17 Rev 1/2001

State Registrar

VIMLUK MD

filed (Month, Day,

JON

oseph

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20

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rked other than "natural; or items 23s or 23s-f si tic event, the Medical Examinat must be notified To Be Completed by Funeral Director	oh rune	<ul><li>I1. Marital Status</li><li>1 ☐ Never Marri</li><li>3 ☒ Widowed</li></ul>			12. Was De Armed I 1  Yes If Yes, C Yeer or	Forces? s 2. ⊠XN Give			Was Decedent of If Yes, specify C 1 ☐ Yes ※☑ N		panic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)			merican Indi /hite, etc. Whit	
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DHMH 16 Rev 6/95

Registrar

GERTRUDE SUPRIK

State of Maryland / Department of Health and Mental Hygiene 200For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SATTERFIEL 2004 SANIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. MANOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign Country)
NOITH CORNING 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F Months Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State or 28a-f ahow Baltimore nucl 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA \*natural", or items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: BLack 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Magnes. Homemaker UKN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 N. Breadway Christmas-nece Balto. Estelle 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 ☑ Burial /2 ☐ Cremation 3 ☐ Removal from State MARYLAND NOTE PALK \* 4 □ Donation 5 □ Other (Specify) 21. Signature of America Licensee 22. Name and Address of Facility 23a. Part I. Enter the disease, excemplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 0 200 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month 0.45AM 30, April 2004 Ethel Claire Sattler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville er Tyear | If Under 24 Hrs 6512 Carroll Highland Road Carrol [ 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🖫 F Min. Yrs. Director 103 27, 1900 Maryland Dec. 213-34-0426 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Sykesville Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6512 Carroll Highland Road 21784 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) homemaker other t awn home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic svent, pice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Lewns Anna Booker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Stapf - daughter 6512 Carroll Highland Road, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \ Burial 2 \ Cremation 3 \ Removal from State
4 \ Donation 5 \ Other (Specify) May 3, 2004 Baltimore, Maryland New Cathedral Cem. 21. Signatur Funeral Service Licens. 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only dine cause on each line. 23a. Part1. Enter the disease of comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ERIOSCEROSIS **Physician** Year /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent prefinant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) Ö the 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and Alle of certified 29c. License number 29d. Date signed (Month, Day, Year) wiles D0020964 May 1, 2004 30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133 3 Registrar's Signature 31. Date filed (Month, Day, Year) MAY 1 0 2004 Registrar

			. For	Type or Print in B State of Marylan	d / Depa	artment of I	Health and M	-	7	4 14871
			1 - State Registrar		Cei	rtificate of	Death		g. No.	
	Physici /Medic		Decedent's Name (First, Middle, La     Jose ph	(st)	Spe	ncer		2. Date of Deat Month MAY	Day Year	
1	Examin	K 400	4a. Facility Name (If not institution, gr	re street and number)			or Location of Death		4c. County of Dea	th
		\$ 4	Johns Hopkins Bar	Inew Medical C	entr		more		N/A	
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs. 1 1 1	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Dey, 09/16/1	916 9. Bit	thplace (State or Foreign ountry)  VA
	Maryland f show	tor	Usual Residence of Decedent  10a. State MD 10b, County BALTIN		y, Town or Lo	cation AS STATIO	N			10d. Inside City Limits 1X☐ Yes 2 ☐ No
	3a or 28a	I Director	10e. Street and Number 107 CARVER ROAD			10f. Zip Code 2122	2	1	0g. Citizen of What C	ountry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If Itam 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Mydical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 14⊡Yes 2 ☐ No If Yes, Give Year or Dates: WWII		Was Decedent of If Yes, specify Cub 1 Yes 2 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecrfy Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:BLA	te, etc.
21215-0036	nin 72 ho n "natur Medical	Completed	15. Decedent's E (Specify only highest gr		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of work ad)	ing	16b. Kind of Business	/Industry
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Maryland 2	ould be filed v I Mental Hygie harked other t hatic event, th	To Be C	17. Father's Name (First, Middle, Las GOODRIDGE SPENCER				18. Mother's Nam		Maiden Sumame)	
ary.	2 should it and Men is marke		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Stree	t and Number or Rur	al Route Number	City or Town, State,	Zip Code)
	1 and 2 Health a am 27 is		OLIVIA SPENCER/WI	FE	107	CARVER R	OAD, BALT	O., MD 2	1222	
<u>o</u>	s 1 a f Hez itam othe		20a. Method of Disposition		lace of Dispo	osition (Name of matory or other pla			20c. Location - City of	Town, Stete
E C	Pages nent of I int: If Its iry or o	ы	1 ☐ Burial 2 ☐ Cremation 3 [  1 ☐ Donation 5 ☐ Other (Special Control of Con	Hemoval from State CP			CEM 5/6/	04 C	ROWNSVILLE	, MD
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Itam 27 any injury or other tr <u>pnca</u> .		21. Signature of Funeral Service Lice		2:	2. Name and Addr	ess of Facility JAM	ES A. MO	RTON & SON	S F.H., INC
- 5	EVEN A		23a. P.m. Enter the disease, or con	nplications that caused the deat	h. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between
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7	Physician /Medical		disease or condition resulting in death)	a. Termina!  Due to (or as a conseq		Pitrattion				10 minuts
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V		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):					01.0
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Il death 3 (	□Ectopic pregnand □ Other (specify)	су		23d. Date of de Month	blivery Day Year
P.0	that the	/ Ph)	Part II. Other significant conditions	contributing to death but not res	sulting in the u	ınderlying cause g	ven in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
rds,	w requires that been signed be should be deta	ed by						1 □ Ye	es 2 12/No 3 ☐ F	robably 4 Unknown
Division of Vital Records,	sician: The law re certificate has bee lirector, page 2 sho	omplet						24a. Was a autops perform	n 24b. Were a prior to death?	utopsy findings available completion of cause of
ita		0	25. Was case referred to medical				26. Place of Dear	th (Check only on	e)	
of V	> 10 P	n: To B	examiner? 1   Yes 2 (VNo  27. Manger of Death	Hospital: 1 Inpatient 2   28a. Date of Injury (Month, Day Year)	28b. Time o	III JUDON			ence 6 Other (Sp.	ecify)
ion	nding ith. :: Afte	atio	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □No			
Divis	after des	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Cartifying F (Check only one) 2 Madicel Exe	Physician: To the best of my kno eminer: On the basis of examina and manner stated.	owledge, dea ation and/or in	th occurred at the nvestigation, in my	time, date and place, opinion, death occur	and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	o the o the omple	Me	29b. Signatury and title of certifier	00		29c. Licer	ise number	2	9d. Date signed (Mor	th, Day, Year)
	F ≯ ⊢ ŏ		Val 1	(5h		16	851		MAY 4,7	2004
	1501		30. Name and address of person who	o completed cause of death (Iter		Print)		enve. Ba	ltimore, N	177
		ate	Valerian R. 31. Date filed (Month, Day, Year)	32. Registrar's Signa		,			.,	
	Regist		MAY 1 0 2004	A A	Local	9 9				

ORIGINAL

			1 - For Amend Item 17 pe Registrar	State of	,05/10/0	nd / Dep Adhb Ce	artmen <i>rtificat</i>	t of H e of L	ealth a	and M			004	14872
	Physici		1. Decedent's Name (First, Middle, Las ZELM)		В.		SIF	RKIN			2. Date of D Month MAY	eath Day 6,	2ŎO4	3. Time of Death 7:45 P M
	/Medio Examin		4a. Facility Name (If not institution, give KESWICK NURSING	street and num			4b. City,	Town, or	Location of	of Death			nty of Death	N/A
D	uneral irector		5. Social Security Number  212-09-9407  Usual Residence of Decedent	x □ M 2	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B. (Month, D. MAY 1	1908	9. Birthp Cour	slace (State or Foreign S.C.
h the Maryland	r 28a-f show	irector	10a. State         10b. County           MD         BALT           10e. Street and Number	IMORE	10c. Cit	ty, Town or Lo	KEYSV 10f. Zip					10g. Citizen		0d. Inside City Limits 1 ☐ Yes 2 📈 No htty?
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or othar traumatic avent. Its Medical Exercitives the notified at once.	by Funeral Director	1425 IVY HILL R0  11. Marital Status  1 Never Married 2 Married  3 WWidowed 4 Divorced	AD  12. Was Deced Armed Ford 1 Tyes 1: If Yes, Give Year or Da	ces? 2∭XNo		Was Deced		210 spanic Ori n, Mexican Specify:		ecify Yes or N Rican, etc.)	0- 14. R B Spec	U.S ace - Americ lack, White, cify:	an Indian,
Maryland 21215-0036 nd 2 should be filed within 72 hours af Ith and Mental Hydiene.	er than "natur t, Its Medical I	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		4or 5+)	(Give	dent's Usua kind of wor DO NOT us TER	rk done d se retired)	luring mos			ADVER	Business/Ind	
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e, Mar 1 and 2 sh	em 27 Is m thar traum		19a. Informant's Name/Relationship (7.  JOAN ROSENBLOOM  20a. Method of Disposition				ELADO!	N RO		OWIN		Der, City or Tow LS, MD 20c. Location	21117	
altimore,	rtant: If ite njury or o		1 M Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify  21. Sign. of e	1/	tate	emetery, cřel GAN AB	natory`or of RAHAM	CEMI	ETERY	5/7	/2004	ROSE	DALE,	MD
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	sician edical		23a. Part . Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. SENILE	^	ENTIA					T406			Interval Between Onset and Death YEARS
Exa	miner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	b	r as a conseq									
8760, cate be executed	physician and s the burial-transi	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (o	r as a conseq	uence of):								
o 🚆	ied by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	Idéath 3□	Ectopic pre Other (spe				-	I	Date of delive Month	ry Day Year
rds, P.	P 6	ρ	Part II. Dther significant conditions co	J		ulting in the u	nderlying ca	ause give	n in Part I.			obacco use co Yes 2 No		e cause of death?
	s certificate has been si lirector, page 2 should	Completed	Atna Jusa	Matu	an .						24a. Was auto perfe 1 \( \text{Yes}		prior to con death?	osy findings available npletion of cause of 2 \square
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DIVISION Of VITA To the Hospital or Attanding Physician: within 24 hours after death.	After this funeral c	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of	-	ER/Outpatier 28b. Time of Injury		Bc. Injury Work	4 CTNU	2		dence 6 🗆 O how injury occi		')
DIVIS tal or Atta s after dea	Funeral Director: stely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of building	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, str	eet, factory	office		2	28f. Location ( City or To		nber or Rural	Route Number,
the Hospi	To the Funeral Directompletely filled in by	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the biner: On the bas and manne	sis of examina	wledge, death tion and/or in	vestigation,	in my op	inion, deat	d place, a	and due to the ed at the time,	date and place	and due to	the cause(s)
Towith	70 FO	2	29b. Signature and title of certifier	aly	mo			) 30	number 943	3		29d. Date sign	07,	2004
7	)		30. Name and address of person who c	670/	N	CHAR		51	•	Bp-	IMOR	e M	0 21	204
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 0 2		gistrar's Signa	lure M								

DHMH 17 Rev 1/2001

ORIGINAL

			Please 1	Type or Print					-		_	
			For State Registrar	State of Mar	-	Departmen Certificat			ientai Hy	giene Reg. No	2HH	4 14873
	Physicia	an	Decedent's Name (First, Middle, Las			_			2. Date of Do	Day		3. Time of Death
>	/Medic Examin	al	Stanley Jose 4a. Fecility Name (If not institution, give		wski,		Town, or Locat	ion of Death	MAY 3,		County of Dea	9.17A
		24	VA MARYLAND HEALTI				POINT	nder 24 Hrs.	2.5		CIL	
	Funeral Director		215-16-7565	M 2□F	(In yrs. last birl 30	Yrs. Months		irs Min.	8. Date of Bi (Month, Di Jan. 15	ay, Year)		rthplace (State or Foreign ountry) aryland
	hours after death with the Maryland turel', or items 23s or 28e-f show at Expringer mast be multiped at	<u> </u>	Usual Residence of Decedent  10a. State 10b. County		Ioc. City, Town			-				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	Directo	Maryland Anne Art	undel	Sev	ern 10f. Zip	Code			10g. Cit	izen of What C	
	23a or		8311 Jacobs Road				2114	4		Uni	ted Sta	
_	ter des Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ XMarried	12. Was Decedent Ev Armed Forces? 1√7 Yes 2 □ No		13. Was Dece If Yes, spe	dent of Hispanio cify Cuban, Me	o Origin? (Spe kican, Puerto	ecify Yes or No Rican, etc.)	D-	14. Race - Am Black, Whi	
5-0036	ours at irel', or LExam	þ	3 ☐ Widowed 4 ☐ Divorced	1 ▼ Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes	2∏ No Spe	cify:			Specify:	White
)-CLZ1	be filed within 72 hours after death with the Marylan the Hygiene, and Hygiene, of other than "naturel; or Items 23a or 28e-f show event, Ite Madical Exerting Inglished at	Completed	15. Decedent's Ed (Specify only highest grader) Elementary/Secondary (0-12)	ucation de co <i>mpleted)</i> College (1-4or 5+)		Decedent's Usu (Give kind of wo life. DO NOT u	al Occupation ork done during : se retired)	most of worki	ng		ind of Business	
17 p	filed w Hygier other ti	e Cor	8th 17. Father's Name (First, Middle, Last)			Brick La	-	lother's Name	(First, Middle		onstruc Sumame)	tion
/lan	Mental Mental arked c	To B	Joseph Antho	ny Twardo	wski			Alice	Sha	рр		
Maryland 2	d 2 sho th and 7 ls mu treum		19a. Informant's Name/Relationship (7			. Mailing Address				-		
ē,	is 1 and Healing Healing 1 other		Gladys M. Twardow		20b. Place of	11 Jacol Disposition (Natry, crematory or o	me of		rn <u>Mai</u> Date		cation - City or	
Baltimore,	Page tment tent: If jury or		1 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	)		erans C	emetery		2004	Crow	msville	e, Maryland
Ra	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent. If item 27 Is marked oth any injury or other treumetic event once.		21. Signalure of Funeral Service Licen	D M	00957	Donal	dson Fu	neral l				
			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only	dications that caused the	ne death. Do r	not enter the mod	Annape I: de of dying, such	is Read n as cardiac o	d Ader or respiratory a	irrest,	Maryla	Interval Between
23	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CEREBRAL			DENT					Onset and Death UNKNOWN
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Box 6	death certificate be executed e attending physician and id for use as the burial-transit	Physiclan/Medlcal	23b. was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		3 ⊟Ectopic p	regnancy				23d. Date of de	
o E	es that the deatt igned by the atte be detached for	ysicl	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tir 9□Unknown		5 ☐ Other (sp					Month	Day Year
ر. ت	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions co	ontributing to death but	not resulting in	the underlying	ause given in P	art I.	23e. Did	tobacco u		o the cause of death?
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Itai	sien: T srtificat ctor, pa	Be C	25. Was case referred to medical examiner?				26. P	lace of Death	1 ☐ Yes (Check only	<b>2</b> √□ No one)	1 Li Yes	5 2 No
	> .0 D	မှ	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury		tpatient 3 DC		-	ne 5 ☐ Resi 28d. Describe		6 □Other (Spe	ecify)
0	ie ite	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Firme of 2 njury M	28c. Injury at Work? 1 ☐ Yes		200. Describe	riow injur	y occurred	
Division of	al or Attending s after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, fa (Specify)	rm, street, factor	y, office	2	28f. Location ( City or To	Street an wn, State	d Number or R )	ural Route Number,
	ne Hospital of 24 hours at the Funeral Distriction of the Funeral Districti	edical (	29a. Certifier 1X Certifying Physics (Check only one) 2 Medical Exem	ysicien: To the best of niner: On the basis of e and manner state	xamination and	n, death occurred d/or investigation	at the time, dat , in my opinion,	e and place, a death occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. a to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License numb	oer		29d. Dat	e signed (Mont	th, Day, Year)
ì			1 Kwz	ilando	C 1		005902			MAY	3, 2004	1
1	P		30. Name and address of person who of JYOTI WALAVALKAR	M.D., VA MA	RYLAND	HEALTH	CARE SY	STEM,P	ERRY P	TAIC	,MD.,21	902
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 0 2004	32. Registrar	s Signature	Spai						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician 2004 Artie Lee Trail May 5:15 AM /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 113 Third Avenue Baltimore Lansdowne If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□F 56 Yrs. Feb 3, Director 223-62-9640 1948 Virginia Usual Residence of Decedent 10d. Inside City Limits 1∩a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Funeral Director Maryland n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3604 Frederick Avenue 21229 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 technician glass and mirror permit. Pages 1 and 2 should be filed v Department of health and Mental Hygiel Important: If item 27 is marked other trans any injury or other traumatic event, that once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Artie M. Trail Virginia Etta Hogston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 113 Third Avenue, Lansdowne, Maryland 21227 John Trail — brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet 5/8/04 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Linensee, 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in dealh) Privsician /ung cances /Medical Due to (or expense of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: NA 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Residence 6 Other (Specify) brother's 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death residence Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed Box 68760. Records, P.O. of Vital Physician: or Attending Division

attending physician and for use as the burial-transit

After

Director: filled in by the

death.

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within 24 hours a To the Funerel L

death with the Maryland

fited within 72 hours after

I Hygiene.

Maryland 21215-0036

Baltimore.

r then "naturel", or items 23s or 28s-f ehow the Medical Exertitive must be notified at

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print) J. HONG M

ORIGINAL

29c. License number

29d. Date signed (Month, Dey, Year)

			1 - For State Registrer	• •	aryland / Depa		lealth and	Mental Hyg	•	
7	Physici /Medic Examir	cal	Decedent's Name (First, Middle, La:     Eula Tanner  4a. Facility Name (If not institution, giver 6510 Gilmore States)  6510 Gilmore States Stat	e street and number)		4b. City, Town, or Wood1		2. Date of Death Month May	Day Yea 3, 2004  4c. County of De Baltir	4:19A M
	Funeral Director			ex 7. Ag	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. B 1922 No	irthpface (State or Foreign Country) cth Carolina
	e Maryland a-f ahow lifted at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Baltin	more	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	th with th	al Director	10e. Street and Number 6510 Gilmore Stre	eet		10f. Zip Code	21207	10	Og. Citizen of What ( United S	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or items 23a or 28a-f show any injury or other treumatic avant, if a Madical Exact retries the indifficit	Completed by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2001 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, lite, etc. White
Baltimore, Maryland 21215-0036	d within 72 ho giene. sr than "natur It a Medical	completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)	ducation ade <i>completed)</i> College (1-4or 5	(Give	dent's Usual Occup kind of work done o DO NOT use retired Housewife	during most of wo f)	orking	6b. Kind of Busines  Own Hor	
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Bait	permit. Departi		21. Signalur of Funeral Service Licer	is Seler	iski 6	Name and Address iller-Dip 415 Belai	ss of Facility pel Fune r Road	eral Home, Baltimore	Inc. Marylar	nd 21206
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or beart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Responded to for all b. Storm	a consequence of a consequence of	Fa: \u.		c or respiratory arre	st,	Approximate Interval Between Onset and Death M. M. n. + C. >
68760,	ficate be executed physician and is the burial-transit	cal	that initiated events 'resulting in death) Last	Due to (or as	a consequence of):					
P.O. Box	The law requires that the death certificate ate has been signed by the attending phypage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
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Divis	tel or Atta 's after de el Directo	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injubuilding, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
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	To the within To the compl	Me	29b. Signature and title of certifier	7-1		29c. License		-00	d. Date signed (Mor	nth, Day, Year)
	5		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print)	2382	2.~ #3	2/5/0	y ned
100	Sta Regist		31. Date filed (Month, Day, Year)	2. Registra	ar's Signature	parket	17	10 47	10/00	wson Mid

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	Examin	er	Facility Name (If not institution, git Johns Hopkins H     Social Security Number 6.	ospital	yrs, last birtho	Balti	r Location of Death MOLE	O. Data of Birth	4c. County	N	/A
355	Funeral Director			1 M 2 X	7   Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day	-1932	9. Birthp Cour	dace (State-or Foreign
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	ath with th	rai Director	10e. Street and Number 4425 57 (	serges 1	Ane	10f. Zip Code	21212		Og. Citizen of W	1.5	A
9036	ours after des ral', or Itams Examiner m	d by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S.	3. Was Decedent of H If Yes, specify Cubs 1 Yes 2 No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		k, White,	an Indian, etc. ACK
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altimor	permit. Pages Department of I Important: If its any injury or of		1 Surial 2 Cremation 3 ( 4 Denation 5 Other (Special Signature of Fungral Service Lice	Removal from State	KING	crematory or other place	R 5-	8-04 SWELI	MAI	Ry 1	AND e Hom
80	ed of Fig. 19		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the yone cause on each line.	death. Do not		ERTY ISK	or respiratory arr	est,	up.	2/20·7 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a <b>Harothorax</b> Due to (or as a co	nsequence of):						Onset and Death
8760,	rate be executed oblysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (ois-ease or kijury that initiated events resulting in death) Last		gular ve	rior vera cav		placenen			
P.O. Box 68760	The law requires that the death certificate be each has been signed by the attending physician age 2 should be detached for use as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date Mon		ry Day Year
rds, P	juires that n signed b	by	Part II. Other significant conditions  Find stage kidney dis	•	_	, ,					e cause of death? ably 4 □Unknown
I Reco		Completed			, ,			24a. Was a autops perform	y pi	rior to cor gath?	osy findings available inpletion of cause of
of Vita	iding Physician: Th th. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner?  **ElYes 2 □ No			tient 3 DOA	4   Nursing no	me 5 Reside	ence 6 Othe		)
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To tha Funaral Diractor: After this certifico completely filled in by the funeral director,	ertification:	27. Manner of Death  1 Natural  2X Accident  3 Suicide  4 Homicide  5 Pending investigating investigating determinent	DO Place of Injury	At home, farm,	m M 1 🗆	Yes 2 <b>√√</b> No	281. Location (St City or Town	on of blooment reet and Number n, State)	or or Rura	ssel during Route Number, Baltimore, M
_	B Hospita 24 hours B Funaral etely fillec	edical C	29a. Certifier (Check only ona)  1 Certifying P 2 Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.	y knowledge, d mination and/o	eath occurred at the ting of investigation, in my of	ne, date and place, a	and due to the ca	ause(s) and mar	ner as st	ated.
	To the within To the comple	Me	29b. Signature and title of certifier	in		29c. License	e number M.E.	2	9d. Date signed May 5,		*
	<b>M</b>		30-Marne and address of person who	completed cause of death		111 Penr	Street,	Baltimo	re, Mar	yland	1 21201
	Sta Registr	9	31. Date filod (Month, Day, Year) MAY 1 0	2004 32. Registrar's S	Signature	April 1	-				

			1 - For State Registrar	State of M	aryland / Depa	artment of Health ar		ene 2004	1487
	Physic	ian	1. Decedent's Name (First, Middle, La Amparo Algaria	·			2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal					May 08	3 2004	7:00 A M
1	Exami	ner	4a. Facility Name (If not institution, given 15619 Norman Dri			4b. City, Town, or Location of C Gaithersburg	Death	4c. County of Death	
	Funeral	_			ge (In yrs. last birthday)	If Under 1 Year If Under 24		Montgomer	4-
0,	Director		578-40-6069	1□M 2□xF	89 Yrs.	Months Days Hours	Min. (Month, Day, ) Mar 25,		place (State or Foreign ntry) CTO RICO
	pur k		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	vention			1041
	Maryle f sho	ŏ	MD Howard		Columbia	realion .			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number		COLUMBIA	10f. Zip Code	100	g. Citizen of What Cou	
	h with	Funeral Director	7070 Cradlerock	Wav		21045		J.S.A.	,
	ems :	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F		14. Race - Americ Black, White,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 X If Yes, Give	No		uerto Rican	Specify: Whi	
9	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show digal Exemilinal must be notified at	ed p	15. Decedent's E	Year or Dates:	16a, Dece	dent's Usual Occupation		b. Kind of Business/In	
212	hin 72	plet	(Specify only highest grant Elementary/Secondary (0-12)		(Give	kind of work done during most of DO NOT use retired)	working	D. KING OF BUSINESSAII	dustry
2	od wit	Completed	12	0011090 (1 40)	'	ior Designer		epartment	Store
Ind	tal Hydrad of the event	Be	17. Father's Name (First, Middle, Last	)			Name (First, Middle, Ma	iden Sumame)	
2	d Mer marke	2	Narciso Algarin  19a. Informant's Name/Relationship (	Time Orient	105 14-17		Cruz		
Maryland 21215-0036	id 2 sl			son		ng Address (Street and Number of Clarksville Pi			
ē,	f Healthern other		20a. Method of Disposition			sition (Name of natory or other place)		c. Location - City or To	
E	Page nent o int: If		1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specif			Mem. Gardens M	ay 12,2004 (	Clarksville	e, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Funeral Serve Lion	1999/		Name and Address of Facility onaldson Funera			,
<b>B</b>	8 9 E 9		white it	2	M00773 3	13 Talbott Ave.	Laurel, Ma	ryland 207	07-4389
	Physician /Medical Examiner	)r	23a. Part 1. Enter the disease, or com shock, or hear takere. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Myocard Due to (or as	dial infarc a consequence of): cy artery d a consequence of,	tion	diac or respiratory arrest	,	Approximate Interval Between Onset and Death
	nsit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		c atrial fi	brillation			
Ć,	exection and rial-tra	Examiner	that initiated events resulting in death) Last	U	a consequence of):	DITITUCION		_	
8760,	ate be executed hysician and the burial-transit	cal		d. Alzheir	mer dementi	a			
Õ	artifice ing ph e as th	Med	IF FEMALE:					, L	
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	Day Year
o,	s that gned b	by P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the ur	derlying cause given in Part I.	23e. Did tobac	co use contribute to th	ne cause of death?
Records,	w require been sig should b	ted 1					1 ☐ Yes	2⊠No 3∏Prob	ably 4 □Unknown
မ် မ	has be	Completed					24a. Was an autopsy	24b. Were autop	osy findings available
	: The cate ha	Con					performed 1 ☐ Yes 2 🔀	d? death?	
Ž	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Death Check only one)		
0	Phys r this ral di	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	I 🔲 Inpatie	ont 2 ER/Outpatient	28c. Injury at	g Home 5 Residence 28d. Describe how	e 6 StOther (Specify	daughter's
0	Attending I ir death. ector: Atter by the funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	255. 5555.155 1104	injury occurred	restachee
Division of Vital	P # in in in	Certification:	3 ☐ Suicide 6 ☐ Could not by determined	28e. Place of Injuding, etc.	ury - At home, farm, stre c. <i>(Specify)</i>	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Itale)	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1⊠ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best niner: On the basis of and manner sta	i examination and/or inv	occurred at the time, date and plestigation, in my opinion, death o	ace, and due to the caus courred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	7		29c. License number		Date signed (Month, L	Day, Year)
,	/		14			D00 592	28	5/10/04	
	5		30. Name and address of person who Dr. ELvira Pasma			Print) Pade Road Suite	109, Laure	L, MD 20724	4
	Sta Registr		31. Date (M:4 Mont) D.D. 2004	532 Begister	s Signature	outs			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004

		-	For State Registrar	State of Maryland / Dep	partment of Health and I ertificate of Death	Mental Hygier	W 0 0	14878
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	John A. Walterh			May	6, 2004	5:02p M
	Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death	
		2	Anne Arundel Me 5. Social Security Number 6. Sex		Annapolis  V)		nne Arun	
975	Funeral Director			M 2□F 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. 2-19-19	27 Mar	place (State or Foreign ntry) Cyland
600	D		Usual Residence of Decedent	10.01.7				
	arylar show	2	10a. State 10b. County MD Howard	10c. City, Town or Ellico	tt City			10d. Inside City Limits 1 ☐ Yes 2 XNo
	the M	Director	10e. Street and Number		10f, Zip Code	10a.	Citizen of What Cour	ntry?
	3a or		4733 Gawain Pla	ce	21043		nited St	•
	death ms 2:	Funerai			B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Americ Black, White,	can Indian,
9	or ite		1 Never Married  Married	1 XYes 2 No	1 ☐ Yes 2 No Specify:	o riloan, etc.)		hite
003	thin 72 hours after death with the Maryland B. "Institral", or Items 23a or 28a-f show Masilcal Examiner out the notified at	d by	3 Widowed 4 Divorced	Year or Dates:	cedent's Usual Decupation	16h	. Kind of Business/In	
15	C	Completed	(Specify only highest grade	e completed) (Giv	ve kind of work done during most of wor . DO NOT use retired)	rking	, Kind of Dusinessan	dustry
212	filed within 7 Hygiene. other than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+) Pres	ident/Owner	P	aper Com	ıpany
Maryland 21215-0036	be filed wit ital Hygiene id other thi event, the	Be (	17. Father's Name (First, Middle, Last)	1		ne (First, Middle, Maid	•	
Z		은	Harry C. Walter  19a. Informant's Name/Relationship (Ty		ROLANGI iling Address (Street and Number or Ru	s Wigman		Code)
ā ≥	tre tre	١,	Angela C. Walte		33 Gawain Place			
ē,	s 1 and 2 f Health item 27 i		20a. Method of Disposition	cemetery c	position (Name of rematory or other place)	Date 20c	. Location - City or To	own, State
E	Page nent o int: If		1 ★ Burial 2 □ Cremation 3 □ R  1 ★ Donation 5 □ Other (Specify)	crestla	wn Memorial 5-1			
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Lions	mate Moosts	22. Name and Address of Facility $Ha$ 4112 Old Columb			
47			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do not e	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	coronary artery	distase			20 Years
	/Medical Examiner		resulting in death)	Due to (or as a consequence of)!				1
		e e		Due to (or as a consequence of):	-thrombosis			1 year
W	d d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
o,	eath certificate be executed attending physicien and for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):				
8760,	cate b	dlcai		1				
9	certification of the second of	0	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delive	Brv
.O. Box	the the	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3   Ectopic pregnancy 5   Other (specify)		Month	Day Year
٥.	ires that the signed by dipe detaction	y Ph	Part II. Dther significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to th	he cause of death?
rds	w require. been sig should b	ed to	non	insulin depen	dent diabetes wells	1 Tes	2 No 3 Prob	pably 4 Ninknown
Vital Records,	e law requ has been je 2 shoul	Completed by				24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of
3		Con				performed 1 ☐ Yes 2 🙀		2 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other:	ath (Check only one)		
ō	ig Phys ter this neral di	.T	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	lome 5 Residence 28d. Describe how in		ý)
ion	nding ath. r: Afte e fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	y Work? M 1 ☐ Yes 2 ☐ No			
Division of	N or Atte after des Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
	To the Hospitel or Attending Ph within Z4 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C		sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.				
	within To the	Me	29b. Signature and title of certifier	4 - Ca A	29c. License number	29d.	Date signed (Month,	Day, Year)
			Dany 1	Milles MD	126621	N	lay 7,20	004
	5		30. Name and address of person who co	ompleted cause of death (Item 23a) (Typ	- 1 - 6	1 4		
		100	31. Date filed (APPA) Day, YPAY)	10 10 Chav 32. legistrar's Signature	TEN DVIVE COLUM	mus mo	21044	
	Sta Regist	ate rar	MAY 1 U 200	4 Geneva &	Sparker			

State of Maryland / Department of Health and Mental Hygiene 2

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	-	= State Registrar			, , , , , ,	Cei	tificat	e of L	Death		R	eg. No.	2004	1.	0/5
Dhysisis		Decedent's Name (First, M									Date of Dea Month		Year		of Death
Physicia: /Medica		Tere	sa M	. Wheeler						M	ay 8,	200	4		0 P M
Examine		4a. Facility Name (If not institu	ition, giv	e street and numbe	r)		_		Location of De	ath			County of Deat		
		31 Locust Pa			\ (I	for an fortunate of a col		ry He	all If Under 24 H	re o r	Data of Diah		altimor		
Funeral		5. Social Security Number 218-54-4408	6. S	M 2 1 7. F	54.	last birthday) Yrs.	Months		Hours Mi	in 7	Date of Birth Month, Day 1ay 16	Year)	9. 811	npiace (Stat untry) Ohio	e or Foreign
Director	-	Usual Residence of Deceden		A	<u> </u>					1	lay 10	, 1:	747	JIITO	
MO		10a. State 10b. Cou			10c. City	y, Town or Lo	cation							10d, Inside	City Limits
등	į	MD Ca	rrol	1		Fink	sburg	3						1 □ Y	es 2∏No
If item 27 is marked other then "naturel", or items 23a or 28a-1 show or other treumetic event. The Medical Examinat must be rediffied at	Director	10e. Street and Number			-		10f. Zip	Code			1	0g. Citîz	en of What Co	untry?	
23a o		4077 Louisvi	11e	Road				21	048			Ţ	JSA		
sme.	Funeral	11. Marital Status		12. Was Deceder Armed Forces		.S. 13.	Vas Dece	dent of Hi	ispanic Origin? n, Mexican, Pu	(Specify	Yes or No-	1	4. Race - Ame Black, White		,
5 E		1 Never Married 2 1		1 □Yes 2X If Yes, Give	No		1 ☐ Yes		Specify:		,			nite	
Exa	d by	3 Widowed 4 Divo		Year or Dates	i:										
dica	Completed	15. Dece (Specify only hi	dent's Ed ghest gra	ducation ade completed)		16a. Deced	lent's Usu kind of wo DO NOT u	rk done d	during most of w	vorking		16b. Kin	d of Business/	ndustry	
reumetic event, the Ms	ď.	Elementary/Secondary (0-1	2)	College (1-4o	r 5+)	me. i		keep	•			C1	erical		
뉱		17. Father's Name (First, Mid	die. Last.			1	DOOL	cicel	18. Mother's N	lame (Fir	st. Middle.				
8	) Be	Robert M									n Mor				
1	0	19a. Informant's Name/Relat				19b. Mailir	na Address	s (Street a	and Number or					ip Code)	
treu		Mrs. Patrici			er)				n Rd.,						
the	1	20a. Method of Disposition			20b. P	lace of Dispo	sition (Na	me of	-	Date		20c. Loc	cation - City or	Town, State	
		1 XBurial 2 ☐ Cremat 14 ☐ Donation 5 ☐ Othe			e !	emetery, crer ke Vie	-		rk 5/1	2/20	)OZ	Syke	sville	MD	
any injury or other tre once.		21. Signature of Funeral Sen			Da										
S S S S S S S S S S S S S S S S S S S	1	> Sugn	1 4	Harlt		S	vkesv	rille	ERAL HO	ME & 784	(410)	ЕL, -795	PA (BO) 5-1400	( 195)	
		23a. Part1. Enter the disease shock, or heart failure.	, or com	plications that caus	ed the death								1.100	Approxim	nate
		shock, or heart failure. Immediate Cause (Final	List only	one cause on each	ling _	- 1	A	1-	1110					Interval E Onset an	
an : cal	- 1	disease or condition resulting in death)	-	a	as a consequ	OM C	L	رحي	1571m						
ner				500 10 (0. 0	20 2 00/1004	uunuu un.									
4	ē	Sequentially list conditions, if any, leading to immediate	- }-	b. Due to (or a	аз а солзеф	uence of j.					_				
	Ē	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	c											
	Examiner	resulting in death) Last	- 8		s a consequ	uence of):									
	ca		l	_ d											
e as the burial-transit	Medical		-						- Contract						
		IF FEMALE: 23b. Was decedent pregnan		23c. If yes, outcom			Ectopic p	regnancy				2	3d. Date of deli	,	V
<u>.</u>	300	in the past 12 months? 1 — Yes 2 XNo		4□Pregnant 9□ Unknown	at time of de		Other (sp		-				Month	Day	Year
	Physician	9 Unknown						-		_					
	by	Part II. Dther significant con	ditions	contributing to death	but not resi	ulting in the u	nderlying o	cause give	en in Part I.				se contribute to		
										-	1 🗆 Ye	es 2 [	No 3EPro	obably 4	∐Unknown
us z	Completed									_ 1	24a. Was a autops		24b. Were au	topsy finding	gs available
page 2	mo;										perform	ned? 2□No	death?	2□ No	
ō	Be	25. Was case referred to me examiner?	dical						26. Place of D	eath (Ch	eck only on	θ)			
ō	9	examiner/ 1 X Yes 2 □ No		Hospital:	tient 2 🗆	ER/Outpatien	t 3 DC	OA Othe	er: 4 🗆 Nursing	Home	5 🗆 Reside	ence 6	ther (Spec	ity) At	scene
		27. Manner of Death 1 Natural 5 □ Pe	ndina	28a. Date of Ir (Month, I	jury Da <i>y Year)</i>	28b. Time of Injury	2	28c. Injun Work	/ at </td <td>28d.</td> <td>Describe ho</td> <td>ow injury</td> <td>occurred</td> <td></td> <td></td>	28d.	Describe ho	ow injury	occurred		
:	atto	2 ☐ Accident inv	estigatio	n		. ,	М		Yes 2 □ No						
ni eni by the in	tific		uld not b termined	288. Place of I	njury - At ho etc. (Specify	ome, farm, str	eet, factor	y, office			Location (St City or Town		Number or Ru	ral Route Ni	umber,
3	Certification:									niko					
				nysician: To the beaminer: On the basis											e(s)
plete	edical	Order A		and manner	stated.								·		
COL	Σ	29b. Signature and title of be	tifier	1			29	c. License	number		2	9d. Date	signed (Month	i, Day, Year,	)
		Il Is	3/1	eny)				O.C.N	1.E.		N	lay 9	9, 2004		
)		30. Name and address of per	son who	completed cause of	f death (Item	n 23a) (Type,		A100 C							
		J. Utken	0	cer. n	4)		11:	1 Per	n Stree	et, I	Baltin	ore,	Maryl	and 21	1201
Stat	- 1	31. Date filed (Month, Day, Y		32. Regis	strar's Signa	iture							_		
legistra	ir .	M/	Y 1	0 2004	\$ 585A5.	J. J.	ASS	AL D							
7 Rev 1/200	01			ció			-								

DHMH 17 Rev 1/2001

		•	1 - State Registrar	State of Marylar			of Health a of Death	and Mental I	Hygiene Reg. No	2001	14880
2	Physici /Medio		1. Decedent's Name (First, Middle, Last) Theodore	zapal	o wic	2		2. Date o Month May	Death Da	y Yeer 2004	3. Time of Death 3 · 20 PM
	Examin		4a. Facility Name (If not institution, give st Bayview Medical	Center		Balti	more,	MD	N	County of Death	
7	Funeral Director		5. Social Security Number 6. Sex 217-01-4892	7. Age (In yrs. M 2 ☐ F	39 Yrs.		ays Hours	Min. Jan	Birth Day, Yeer 1, 19	15 Mar	place (Stete or Foreign nto) y Land
	death with the Maryland ims 23s or 28s-f show	ctor	10a. State 10b. County MD N/A		ty. Town or Lo Ltimor						10d. Inside City Limits 1
	uth with the	al Director	359 Folcroft St			10f. Zip Co 212	24			tizen of What Cou	
	y within 72 hours after death with the Marylan jiene. r than "naturel", or items 23a or 28a-f ehow the Modical Examinat man be collilled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Be Yes 2 □ No If Yes, Give Year or Dates: WW I ]		Was Decedent II Yes, specify 1 ☐ Yes 2 🛣	Cuban, Mexican	gin? (Specify Yes o i, Puerto Rican, etc.	r No-	14. Race - Ameri Black, White Specify: Wh	, etc.
21215-0036	within 72 hou ene. then "nature he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+) N/A	(Give	dent's Usual O kind of work d DO NOT use r	lone during most etired)	t of working		ind of Business/Ir	ndustry
	thould be filed wid Mental Hygie marked other timetic event, ID	To Be Co	17. Father's Name (First, Middle, Last)  Bronislaus Zawon		TILE	right	18. Mothe	n's Name (First, Mic			vice
, Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (Type Mrs. Clara Zapa	lowicz	359 E	olcro	ft Str	eet Ba	ltimo	re. MD	21224
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	St.	semetery, crei Stan		s Ceme	. 5-10-0	)4 в	alt., N	MD
Bal	permit. Depart Import eny inj		21. Signature of Funeral Service License  23a. Part1. Enter the disease, or complice	<u> </u>	12	OI Du	ndalk_	Avenue l	Balti	Funera more, N	al Home, P MD 21222 Approximate
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Due to (or as a consec	Rena	1 Fo	عاليد	ourding of respirate	y unost,		Interval Between Onset and Death
8760,	Examiner	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Sebsis  Due to (or as a consec  Atnial  Due to (or as a consec	quence of):	bei]]	atien				2 weeks. > 1 year
.O. Box 68	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	el death 3	⊒Ectopic pregr ∃ Other (specif				23d. Date ol deliv Month	ery Day Year
<u>α</u>	law requires that the as the or signed by the 2 should be detached	eted by Ph	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying caus	e given in Part I.		id tobacco		he cause of death?
Vital Records,	The ate h page	Complet						a	Vas an autopsy enformed? es 2 Mo	prior to co	opsy findings available impletion of cause of
ō	tending Physi ian: Theath. for: After this critificate the funeral director, pag	To Be	27. Manner of Death 1 XNatural 5 Pending	ospital: 1 MInpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		Othor		500 50		( <b>5</b> /)
Division	tal or Attending s after death. af Director: After ed in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	lome, farm, sti fy)	reet, factory, of	fice		on (Street ar Town, State	nd Number or Run e)	al Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only 2 Medical Exemin	ician: To the best of my known: or: On the basis of examination and manner stated.	owledge, deat ation and/or in	vestigation, in	my opinion, deal	d place, and due to th occurred at the ti	me, date an	d place, and due t	o the cause(s)
	To the within 2 To the complete	2	29b. Signature and title of certifier  Authorities  29b. Signature and title of certifier	MD			5742	7	29d. Da	ite signed (Month,	2004
(	0		30. Name and address of person who con Rayiv Thank	mpleted cause of death (Item 32, 4940 32, Registrar's 99n	Easte	on Av	imic, I	HBMC	Bal	timane 1	nD21224
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1	0 200 S	en de	1 Los	we s				

State Registrar

DHMH 17 Rev 1/2001

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we

29b. Signature and title of certifier

30. Name and acc.

YANGANTA

Glad (Month, Day,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

MV)

O.C.M.E.

May 08, 2004

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2000

Prysician   As Pauly water   As Pauly				1 - State Registrar  Ce	ertificate of Death	Reg	eues O O d 1 d O G	16
Function    Total Control   Control		/Medic	al		Ab City Town or Location of Death	May	10 2004 8:00 A	
Referred Sales    Tr. Faither's Name (First, Middes, Last)   Suzanne Sterling		Funeral Director	er	1603 Park Avenue  5. Social Security Number  212-38-1663  Usual Residence of Decedent  6. Sex 1 M 2 □ F 65  7. Age (In yrs. last birthday 1 M 2 □ F 65  Yrs.	Baltimore   If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth	N/A  9. Birthplace (State or For	
Received Sales   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Manows Jumana)   19. Mother's Name (First, Middle, Manows Jumana)   19. Mother's Name (First, Middle, Last)   19. Mother's Name (First, Middle, Manows Jumana)   19. Mot		th with the Maryl 23a or 28e-f sho		10e. Street and Number	10f. Zip Code	10g		]No
Referred Sales    Tr. Faither's Name (First, Middes, Last)   Suzanne Sterling	3036	nours after dea ural', or items   Examinat m	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give		pecify Yes or No- o Rican, etc.)	Black, White, etc.	
Robert J. Ashton  Same Relationship (Type, Print)  196. Mailing Address (Street and Number or Plans Robus Number, City or Town, State, Zie Code)  Andrew S. Ashton/Son  101 W. 39th Street Baltimore, MD 21210  206. Place of Disposition (Number of Plans Robus Number, City or Town, State, Zie Code)  Andrew S. Ashton/Son  206. Place of Disposition (Number of Plans Robus Number, City or Town, State, Zie Code)  Andrew S. Ashton/Son  206. Place of Disposition (Number of Plans Robus Number, City or Town, State, Zie Code)  Bayview Crematory, INC 05/12/2004 Baltimore, MD 21210  207. Plans Robert S. Ashton/Son  208. Plans Robert S. Ashton/Son  208. Plans Robert S. Ashton/Son  209. Plans Robert S. Ashton/Son  209. Plans Robert S. Ashton/Son  209. Plans Robert S. Ashton/Son  200. Plans Robert S. Ashton/Robert S. Ashton/R	21215-(	led within 72 h ygiene. her than "natu it, the wedica		(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12  Ret	e kind of work done during most of wor DO NOT use retired) ired Sales	C.	lothing Mfg.	
23a Part. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the mode of dying, such as cardac or respiratory arrest.   Approximated the death of the dea	aryland	should be fill and Mental H s marked ott	To Be	Robert J. Ashton	Suzanne	Sterling		
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Sequentially list conditions.  If any, legading to immediate cause (Final Index) list only one cause on each line.  Sequentially list conditions.  If any, legading to immediate cause (Final Index) list only one cause on each line.  Sequentially list conditions.  If any, legading to immediate cause (Final Index) list only one cause on each line.  Due to (or as a consequence of):  23d. Date of delivery  Month Day  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the contribute to the cause of the contribution of the contrib	Balti	permit. Dep.rtm Imp.crte any nju		21. Signature of Funeral Service Licensee	terling Ashton Sc 36 Edmondson Ave.	hwab Funer Baltimor	ral Home, Inc. re, MD 21228	
Second   S	Je	/Medical Examiner	ner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):			Interval Betweer Onset and Death	
The state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   3   Probably   4   Yes   2   No   4   Ye		tificate be execute ig physician and as the burial-trans	edical	that initiated events resulting in death) Last   C. Due to (or as a consequence of):  d.				
1   Yes 2   No 3   Probably 4   No state of the date of the position of death   1   Yes 2   No 3   Probably 4   No state of the position of death   1   Yes 2   No 3   Probably 4   No state of the position of death   1   Yes 2   No 3   Probably 4   No state of the position of death   1   Yes 2   No 3   Probably 4   Yes 2   No 3   Probably 4   Yes 2   No 3   Probably 4   Yes 2   No 3   Probably 4   Yes 2   No 3   Probably 4   Yes 2   No 3   Probably 4   Yes 2   No 3   Probably 4   Yes 2   No 3   Probably 4   Yes 2   No 3   Probably 4   Yes 2   No 3   Probably 4   Yes 2   No 4   Yes 2	.O. Box	t the death cer by the attendir ached for use	hysiclan/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Pregnant at time of death 5				
25. Was case referred to medical examiner?  1   Yes   Yes   No   Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   1   Natural   2   No   Input   1   Natural   2   No   No   Input   1   No   No   No   No   No   No   No		w requires tha been signed should be del	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 ☐ Yes	2 No 3 Probably 4 Wunkno	own
29a. Certiflier (Check only one)  29a. Certiflier (Check only one)  29b. Signature and title of certifler  29b. Signature and title of certifler  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  WMP # P18308 Through JHH 5/10/04	/ital Re	cien: The la entificate has ector, page 2		examiner?		performe 1 ☐ Yes 2 🗷 th (Check only one)	d? death? 1 No 1 ☐ Yes 2 No	of
29a. Certiflier (Check only one)  29a. Certiflier (Check only one)  29b. Signature and title of certifler  29b. Signature and title of certifler  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  WMP # P18308 Through JHH 5/10/04	ion of \	ending Phyei sath. or: After this c he funeral dire	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  1 Inpatient 2 EH/Outpatie 28a. Date of Injury (Month, Day Year)  28b. Time Injury	of 28c. Injury at Work?			
mug woluty MD, PhD UMP # P18308 through JHH 5/10/04	Divis	epitel or Att. nours after de nerel Directe filled in by ti		4 Homicide  determined  239. Place of injury. At norms, farm, s building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	City or Town, S	State) se(s) and manner as stated.	
		4	Medic	(Check only one)  2 Medicel Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	29c. License number	rred at the time, date	and place, and due to the cause(s)  Date signed (Month, Dey, Year)	-
1830 BUILDING E. MONUMENT STREET, ROOM 402, BOLTIMONE MD 21205; Johns Hopkins  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature,		Sta Registr	100	1830 Building E. Monument street, R	com 402, Baltimon	e MD 2120	5; Johns Hopkins Its	juta

			For State Registrar	State of M	laryland / [	Department of F Certificate of		-	giene Reg. No. 200	4 11.00
			1. Decedent's Name (First, Middle,	Last)				2. Date of De. Month	seed of a	3. Time of Death
3.5	Physici /Medi		ANNA ARNOL	D				May	6 2004	1800 PM
)	Examir	ier*	4a. Fecility Name (If not institution,				or Location of Death		4c. County of Death	1
			UNION MEMOR  5. Social Security Number		'AL ge (In yrs. last bir		IMORE If Under 24 Hrs.	8. Date of Birt	NA th 9. Birth	polace (State or Foreign
	Funeral Director		214-09-0584	1 ☐ M 2 🂢 F	96	Monthe Dave	Hours Min.	JAN 6,	y, Year) Con	nplace (State or Foreign untry)UK
7	3		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Lagation				10d. Inside City Limits
5	e hov	ō			Too. Oity, Yow					1 X Yes 2 □ No
t at	28a-1	Director	MD 10e. Street and Number	NA		BALTIMORE 10f. Zip Code			10g. Citizen of What Co	untry?
13	3a of		4800 SETON D	RIVE		213	215	:	USA	
teap	ems 5	Funeral	11. Marital Status	12. Was Deceden Armed Forces		13. Was Decedent of H		ecify Yes or No Rican, etc.)		
21215-0036 States death with the Manyland	perint. Fages I and Should be liked white 72 flouts after beauth with the wasyran broadward of Health and Mentalla Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examene must be institled at ance.	by	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced		No	1 □ Yes 2 No	Specify:	,		HITE
5-0	"natu	Completed	15. Decedent's (Specify only highest		16a.	Give kind of work done	during most of work	ing	16b. Kind of Business/I	ndustry
121	than than	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use retired			ggwaa	
22	Hygir Sther ent, I		17. Father's Name (First, Middle, La	· · · · · · · · · · · · · · · · · · ·		EDUCATO		e (First, Middle,	SCHOO Maiden Sumame) UN	
lan E	Mental Med of	To Be								
Maryland	and N		19a. Informant's Name/Relationshi	(Type, Print)	19b	. Mailing Address (Street	and Number or Rur	al Route Numbe	er, City or Town, State, Z	ip Code)
Z ,	m 27			ARDIAN)		O N. CALVERT		BALTI	MORE, MD 21	202
ore	if ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	Removal from State	cemete	f Disposition (Name of ry, crematory or other place	ce)	Date	20c. Location - City or 1	fown, State
Baltimore,	rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Signature Line 1)		MT. Z	ION CEMETERY 22. Name and Addre		3, 2004	LANSDOWNE	
Bal	Depa Impo		21. Signature of Funer Sprice		-		LMOR STRE		VERAL HOME P LTIMORE, MD	A 21217
g I v	7		23a Part1. Enter the disease, or c shock, or heart failure. List of	omplications that cause	ed the death. Do					Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	•		RATORY	DIST	ECC.		Onset and Death
14	/Medical		resulting in death)		s a consequence		210/16	607	-	70 1119
	xaminer	L	Sequentially list conditions	b. —		Wile - III				
7	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	or):				
7	ate be executed hysician and the burial-transit	Exar	that initiated events resulting in death) Last	c Due to (or a	s a consequence	of):				
8760,	ysicia e buri	dlcall		d						
9	2 4 (0	Med	tF FEMALE:							
Вох	attrice trendi	lan/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		у		23d. Date of deliments	very Day Year
P.O. 1	inal the death ceruing ed by the attending detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant : 9⊡ Unknown	at time of death	5 ☐ Other (specify) _				,
	ned by detac	y Ph	Part II. Other significant condition	s contributing to death	but not resulting i	n the underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ords,	w requires that s been signed to should be det	Completed by	CORDNARY	ARTERY	DISE	ASE	ŧ	101	Yes 2 No 3 Pro	bably 4 Unknown
ecol		plete	DEMENT	14				24a. Was	an 24b. Were au	opsy findings available omptetion of cause of
Re	p	mo						autop perfo	rmed'// death?	2 D2 No
/ital	is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Deat			
of Vita	S D	은	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpat			4 I Italishig Ho		dence 6 Other (Spec	ify)
on C	After	tlon	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investiga	28a. Date of In (Month, D	ay Yeer)	Time of 28c. Injury Wor	rk? Yes 2 □ No	28d. Describe r	how injury occurred	
Division of Vital Records,	or Attention after death Director:	Certification:	3 Suicide 6 Could no	4 h =	njury - At home, fa	arm, street, factory, office	100 2 2 2 110		Street and Number or Ru	ral Route Number,
	s after	Serti	4 Homicide	building, e	atc. (Specify)			City or Tov	vn, State)	
9	to the nospite or Attending From within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical (	29a. Certifier Certifying (Check only one) Certifying	Physician: To the best caminer: On the basis and manners	of examination ar	e, death occurred at the tind nd/or investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
Š	within 2 To the I	Z e	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Month	, Day, Year)
	71.0		Stateoux	Hillonar	2	D.	58860		MAY 6,	2004
	ĺ		30. Name and address of person w		death (Item 23a)	(Type, Print)		044		
	1		SHAWN DHI			201 E. UNIV	ERSITY	PKNY	ismo, M	0 61218.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1		trar's Signature					
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315	50		For State	State of Ma	arylan					ntal Hygi	ene	11.001
			State     Registrar     Decedent's Name (First, Middle, Last)			Cei	tificate of	Deam		Re Date of Death	g. No. ZUJL	3. Time of Death
	Physicia			TCTIM A N						Month May 9,	Day Year	0337 P M
	/Medic Examin		JASON TRAVIS BAI  4a. Facility Name (If not institution, give	IGHMAN street and number)			4b. City, Town,	or Location o			4c. County of Death	
1	LAGITIT	Ç.	University Hospit	al			Baltin	nore				
	. Funeral		5. Social Security Number 6. Sec	7. Ag	e (In yrs. I	ast birthday)	If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		251-49-0116	IM ZUP	22	Yrs.				10-19-1	981	SC
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary -f sh	to	MD N/A		В	BALTIMO	RE					1∭Yes 2□No
	h the	Funeral Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of What Cou	ntry?
	23a c	la	2451 LAURETTA AVEN	IUE			212				USA	
	tems	nue	The trainer states	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Orig ban, Mexican	gin? (Specif n, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	
36	rs afte	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XI If Yes, Give Year or Dates:	No		1⊡Yes 2∭XNo	Specify:			Specify:	ACK
8	72 hours after death with the Maryland Insturet, or Hems 23a or 28a-f show disal Exact must be notified at	ted	15. Decedent's Edu	cation		16a. Deced	ient's Usual Occu	pation		1	6b. Kind of Business/Ir	
215	within 73 ene. than "n	Completed	(Specify only highest grad	College (1-4or 5	5+)	(Give life. I	kind of work done DO NOT use retir	e during most ed)	t of working			
2	filed withi Hygiene. other than ent, the N	Con	11		·							
pu	tal Hy	Be	17. Father's Name (First, Middle, Last)								laiden Sumame)	
yla	2 should be filed within and Mental Hygiene. is marked other than eumatic event, the Ma	2	SAMMY C. BAUGHMAN  19a, Informant's Name/Relationship (Ty	no Drintl		10h Mailie	- Address /Ctros		D. OV		City or Town, State, Zi	Code)
Maryland 21215-0036	d 2 st th and th and 7 is n treur		GIA D. OWENS/MOTH	•			LAURETT.				MARYLAND	21223
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturet, or Items 23a or 28a-f show any nijury or other treumatic event, It a Madical Exar. it at must be notified at once.		20a. Method of Disposition		20b. P		sition (Name of natory or other pl		Date		Oc. Location - City or T	own, State
Baltimore,	Pages nent of h ent: If ite ury or of		1 Burial 2 Cremation 3 F  1 Donation 5 Other (Specify)	lemoval from State			natory or other pi.		5-14	1-14 1	Zandallston	n, Md-
aĦ	mit. F partm sorter / inju	ĺ	21. Signature of Funeral Service Licens	90 A	11.1.1					The second secon		S F.H., INC.
m	Depar Impo any ir		James G. W	forton 1	1	17	701-31 L	AURENS	ST.	BALTIM	ORE, MARYL	AND 21217
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each li	d the death	n. Do not ent	er the mode of dy	ing, such as	cardiac or re	espiratory arre	st,	Approximate Interval Between
	Pnysician .		Immediate Cause (Final disease or condition	/M	ultid	6 gui	shot w	ounds	\$			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a cons	uence 🐠						
	Ą	<u>.</u>	Sequentially list conditions,	Due to (or as	a consequ	uence of:						
	ned neit	Examiner	Sequentially list conditions, if any, leading to immediate cause. End of Jarying Cause (Disease or injury								7	
2	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):						
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d								
9	ntifica ng ph as th	Med	IF FEMALE:									
Вох	death certifica a attending ph d for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 🗌 Fetal	Ideath 3□	Ectopic pregnan	су			23d. Date of deliv Month	ery Day Year
0.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of de	eath 5L	Other (specify)					
٥	that the de ed by the detached		Part II. Other significant conditions co	ntributing to death b	out not resu	ulting in the u	nderlying cause g	iven in Part I.		23e. Did tob	 acco use contribute to t	he cause of death?
Records,	uires tha signed Id be det	Completed by								1 🗆 Ye	s 21X No 3 □ Pro	bably 4 DUnknown
CO	w requires been si should I	lete								24a. Was an		opsy findings available
Re	The lar	шо								autopsy perform 1 Yes 2	ed? prior to co death? □ No 1 🗓 Yes	empletion of cause of
of Vital		0	25. Was case referred to medical					26. Place	of Death (C	Check only one		20.00
Į (	Physician: this certific ral director,	To B	examiner? 1 XYes 2 □ No	lospital: 1 ☐ Inpatie	ent 2X	ER/Outpatier	t 3 DOA	ther: 4 🗆 Nu	rsing Home	5 🗆 Resider	nce 6 Other (Speci	fy)
	ding Pi After ti funera		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	iry ly Year)	28b. Time of Injury	W	ork? 🔑			winjury occurred was Shot	-
Sio	death. ctor: A	catl	2 Accident investigation 3 Suicide 6 Could not be	5-9-04		2:30		Yes 2 ሺ 1				
Division	for Attencafter death	Certification;	4 Homicide determined	building, et	ic. (Specify	/) .	eet, factory, office tyee t	•		City or Town,	eet and Number or Rur State) N. Www	ick Ave and
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 ☐ Certifying Phy	sician: To the best	of my kno			time, date and	-	mondson	Butimera use(s) and manner as s	
	To the Hospitel within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Exami	ner: On the basis of	f examinat	tion and/or in	vestigation, in my	opinion, deat	th occurred	at the time, da	te and place, and due t	o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licer	nse number		29	d. Date signed (Month,	Day, Year)
	/1		I him his	miD			0.C	.M.E.		M	ay 10, 200	1
	1		30. Name and address of person who co	-	death (Item			Charac	4 P-7	l de deserve	Wa	21201
				D Dominto			itt keun	stree	t, Bal	rtimore	, Maryland	21201
1	Sta Registi		31. Date filed (Month, Day, Year)	32. Registr	ar Signa		Snoot	٠ او				

		1 - For State Registrar	State of Man	yland / De		Health and I	-		200	
Physic /Medi Examir	cal	Decedent's Name (First, Middle, La     Asako      4a. Facility Name (If not institution, give	Вз	own	4b. City. Town.	or Location of Death		eath Day		3. Time of Death 1:45 P
Funeral Director	lei	5202 Tilbury  5. Social Security Number 153-32-4394	Way	n yrs. last birthda 74 Yrs	Balti	Imore	8. Date of Bi	rth ay, Year)	N /	
e Maryland 3e-f show	ctor	Usuel Residence of Decedent  10a. State 10b. County  Mary Land N/A		oc. City, Town or Baltimo						10d. Inside City Limits 1    Yes 2 □ No
th with th	ai Dire	10e. Street and Number 5202 Tilbury Way	4		10f. Zip Code 21212			10g. Citi USA	zen of What C	Country?
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f show eumatic event. It a Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ ▼ ivorced	12. Was Decedent Eve Armed Forces? 1 Pes 2 No If Yes, Give Year or Dates:	or in U.S. 1	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No	an, Mexican, Puerti	pecify Yes or No o Rican, etc.)	0-	14. Race - Am Black, Wh Specify:	
within 72 ho ene. than "natur he Medical i	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	(Gi	cedent's Usual Occu ive kind of work done o. DO NOT use retire Outer Prog	during most of word d)	king		nd of Busines	s/Industry
ould be fited Mental Hygie arked other stic event.	To Be Co	17. Father's Name (First, Middle, Last, Yoshitaro Miyata	)	GOIII	parer 110g	18. Mother's Nam Kame Gat			outer Sumame)	
permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other treumatic evonce.		19a. Informant's Name/Relationship ( Leslie Misa Zuga/ 20a. Method of Disposition	/Daughter	520 20b. Place of Dis	ailing Address (Street  2 Tilbury  sposition (Name of	Way Ba.	ral Route Numb Ltimore, Date	MD	7 Town, State, 21212 cation - City o	
permit. Pages Department of Important: If it any injury or c		1 Burial 2 Cremation 3 4 Donation 5 Other (Specifical Signature of Funeral Service Liger	Removal from State (y)	cemetery, c	rematory or other pla rematory I 22 Name and Addre Cremation	nc. 5-11	L-04		timore.	
Physician /Medical Examiner physician and physician and the prizel-transit	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Squentially list and this if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	one cause on each line.	DOMA onsequence of):	OF T			rrest,		Approximate Interval Between Onset and Death
at the death certificat by the attending phy tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic pregnance 5 □ Other (specify) □	у		2	3d. Date of de Month	livery Day Year
The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant conditions of	contributing to death but n	ot resulting in the	underlying cause giv	ven in Part I.			se contribute t	o the cause of death?
	Completed								24b. Were a prior to death?	utopsy findings available completion of cause of
Attanding Phy r death. octor: After this by the funeral d	Certification: To Be	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Ye	At home, farm,	of 28c. Injur Wai	v at	ome 5 Residence 1	dence 6 how injury	occurred	ocify) ural Route Number,
To the Hospital or within 24 hours after To the Funeral Direct moletely filled in L	Medical Co	one)	ysician: To the best of miner: On the basis of exa	amination and/or	investigation, in my o	pinion, death occur	red at the time,	date and	place, and due	to the cause(s)
1 P P P P P P P P P P P P P P P P P P P	A	29b. Signature and title of contrier  30. Name and address of person who	completed cause of death	(Item 23a) (Tue		5194	/		10, 2	
Sta Registr	te		JOHNS HIPP	EINS CA		Ep. 400 A	1. BRCAL	DWAY	BALT	INORE MOZ

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	tate of Marylar	-	artment of H tificate of I		-	giene Reg. No. 2 (	004	14886
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	Year	3. Time of Death
	Physici /Medic		Sharon	Elaine Day	is Ba	xter		May 5	, 2004	1941	0750 A. M
>	Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or		Death	4c. Count	y of Death	
			1561 Farlow Avenue  5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	Crof	ton If Under 24	Hrs. I a Date of Bir		Arun	
	Funeral Director			2 T 5		Months Days		Hrs. 8. Date of Bir (Month, Date of OCT 9.	y, <sub>Year)</sub> 1947		place (State or Foreign ntry) CV1and
			Usual Residence of Decedent					1001 2,	1.251		
	nylan show	_	10a. State 10b. County		ty, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Director	Maryland   Anne Arun	del		Crofton	1	1			
	a or 2		10e. Street and Number 1561 Farlow Avenue	3		10f. Zip Code 211	14		10g. Citizen of	USA	ury?
	er death with the Marylan Items 23a or 28a-f ehow Increase by Excelling at	Funeral	11. Marital Status 12.	Was Decedent Ever in U	J.S. 13. V	Vas Decedent of Hi	spanic Origin	? (Specify Yes or No	- 14. Ra	ce - Americ	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23s or 28s-f ehow other treumatic event, Item Medical Ectricia at missible recilified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	ŀ	fYes, specify Cuba I□Yes 2∑X No	n, Mexican, P Specify:	Puerto Rican, etc.)	Speci	nck, White, Ty: Wh:	<sub>etc.</sub> ite
2-0	72 ho	Completed	15. Decedent's Educati (Specify only highest grade co	on ompleted)	(Give	lent's Usual Occupa	lurina most of	f working	16b. Kind of E		
21	vithin hen "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	)	J	Unive	-	of
2	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	5+	Ins	tructor	18. Mother's	Name (First, Middle	Maryla		
and	ould be t Mental I warked o	o Be	Ernest M. Davis				Ruby			,	
Maryland	should Ind Menion Ind Menion Ind Menion Indianation	2	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a	and Number o	or Rural Route Numb	er, City or Town	, State, Zip	Code)
	and 2 ealth a m 27 Is		Benjamin S. Baxter/	Son	521 1	N. Graham	Stree	t, Apt. 31	Charle	otte,	NC 28202
ore	of He of He If Item		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Rem	oval from State	cemetery, cren	sition (Name of natory or other plac	-	Date	20c. Location	- City or To	own, State
Ë	Pag trnent tent: jury c		`4 □Donation 5 □Other (Specify)	Met		matory, 1			Baltir	nore,	MD
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signa are a Funeral Service Doensee  Edward A. Gregor	chik	22 C	Rame and Address remation 99 Frede	is of Facility Societ cick Ro	ty of MD, pad Baltim	Inc. ore, MI	2122	28
ш			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the dea ause on each line.				rdiac or respiratory a			Approximate Interval Between Onset and Death
	Physician .		Immediate Cause (Final disease or condition resulting in death)		Ju	-ging					Chick and Boath
	/Medical Examiner		rosoning in addition	Due to (or as a consec	quence of):	1 1					
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):						
	Id ansit	Examine	cause. Enter Underlying Cause (Disease or Injury that initiated events							- 1	
ó,	icate be executed physician and s the burial-transit	Exc	resulting in death) Last	Due to (or as a consec	quence of):						
68760,	ate bu	dicai	d								
<b>Q</b>	se as		IF FEMALE: 23c	if yes, outcome of pregn	ancv				224 5		
Вох	death certific e attending p id for use as	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)				ate of delive onth	Day Year
0	0 0 0	hysi	1	9□ Unknown							
ls, P	Se Lie	by	Part II. Dther significant conditions contrib	outing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did t	V		ne cause of death?
ecord	w require been sig	Completed						-	1		
Rec	hast ge 2 s	mpi						24a. Was autor perfo		prior to cor death?	psy findings available mpletion of cause of
la		e Co	25. Was case referred to medical				26 Place of	Death (Check only o	2 No	1 Yes	2 No
Vital	Physicien: this certific ral director,	0 8	examiner?  1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe	ar	ng Home 5 Resid		her (Specif	ν)
οl		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		28d. Describe			[
Division	or Attending after death. Director: Afte in by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation	UNK	Ma	M 10		Subje	it ha	ngeo	Iself
Ž	for Attendate death Director:	rtific	3 Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building etc.   Sp = i	ome, farm, stre	et, factory, office		28f. Location (: City or Tox	Street and Num vn. State)	ber∮r Rura ∧	I Route Number,
	Hospitel (24 hours a: Funeral Dittel) filled i		29a. Certifier 1 ☐ Certifying Physici	an: To the best of my known	DIM	- CA	060	1361	Taylou	S DV	८ भाग
	9 Hos 24 ho Fun etely	Medical	(Check only 2 Medical Examiner	On the basis of examination and manner stated.	ation and/or inv	estigation, in my of	pinion, death	occurred at the time,	date and place,	and due to	the cause(s)
	To the Hospitel within 24 hours of To the Funeral I completely filled	Me	29b. Signature and attle of certifier	^		29c. License O.C.I	number		29d. Date signe	ed (Month,	Day, Year)
	18		) Clarke	au()		0.0.1	• شد • د		May 5,	2004	
	10		30. Name and address of person who comp	leted cause of death (Iter	m 23a) (Type,	Print)	nn Str	eet, Balti	more M	(arols	and 21201
		3	31. Date file Manual Town 18 19 19 19 19 19 19 19 19 19 19 19 19 19	CE LONG	aver	backs	- OLL	COUP DUILUI		Y.C.	TATE CITAL
	Sta Registi		mmr 1-1 2004	<b>)</b>	Je Je	yours.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 10:42 AM May Banks 2004 Margaret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Union Mem. Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) 3-14-30 Birthplece (State or Foreign Country) **Funeral** 1□ M 3€ F 74 Director 214-26-0799 Va. Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral', or itams 23a or 28a-f show Examiner must be notified at Yes 2□No Md. Baltimore Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 633 N. Aisquith Street Apt. 3 H 21202 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant 1 fem 27 is marked other then "natural", or its 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced other then "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Varies Shop 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claudius Fowlkes Bessie 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 328 Sweetbriar Ct., Joppa, Md. Stephanie Brinkley other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 5-11-04 Owings Mills, Md. permit. 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Physician 7 dans ac do 5 3 Severe /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discuss or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last burial-t Due to (or as a consequence of): ng physician as the burial Box 68760, Physician/Medical attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown ል signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 **N**No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? Yes 2 V No certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient ÷ 2 2 ER/Outpatient 3 DOA this 27. Mannef of Death ↑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: A 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide o 24 hours aft Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Fune completely fi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946-620 Cecilia Wan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East University Parkway Baltimore, mD 21218 Cecilia Wang 201 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 1 1 2004 State Registrar

			For A1 T 00	State of Marylar				fental Hygie	•	
			<b>1 -</b> For Amend Item 23a p	er Dr.,6831,05/1	Certific	ate of De	ath		No. 2004	14888
(\$c.	Physici		1. Decedent's Name (First, Middle, Last)	POICES					Day Year 29 2004	3. Time of Death 3.20 AM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. C	ity, Town, or Loc	ation of Death	7.071	4c. County of Death	
	Funoral	#. <u>.</u>	5. Social Security Number 6. Sex	7. Age (In yrs.			Under 24 Hrs.	8. Date of Birth	9. Birth	place /State or Foreign
e. §	Funeral Director		214-30-3916 1	M 20 F (9	Yrs. Mont	hs Days Ho	ours Min.	8. Date of Birth (Month, Day, Ye	Co.	place (State or Foreign
	yland how		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Location					10d. Inside City Limits
	the Mar 28a-1 s	ector	10e. Street and Number		Batti	MONE Zip Code		10-	Cirile and Alathan Co	1 Yes 2 No
	72 hours after death with the Maryland hatural, or itams 23a or 28a-f show dicel Exercities at	Completed by Funeral Director	2301 Pentland	Drive Ant	105	2123	34	Tog.	Citizen of What Cou	intry ?
	ler dea	uner	11. Marital Status  1 Never Married Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No	J.S. 13. Was De If Yes, s	cedent of Hispan specify Cuban, Mi	nic Origin? (Spenican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
9036	ours aff	d by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 □ Yes	s 200 No Sp	ecity:		Specify: B	IACK
21215-0036	in 72 h "natu Iealicul	oletec	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's U (Give kind of life. DO NO	work done during	g most of work	ing ,	. Kind of Business/Ir	ndustry
	filed within Hygiene. other than "	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	ElECTI	ical 1	Mech	anic	Electi	ican
and	d be fill ental H ked oth c even	To Be	17. Father's Name (First, Middle, Last)	45		18.	Mother's Name	(First, Middle, Maid	den Sumame)	
Maryland	nit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan artment of Health and Mental Hygiene. critent: If item 27 is marked other than "natural", or itams 23a or 28a-f show injury or other treumatic event, II a Medical Examinat must be publified at 9.	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailing Addr	ess (Street and N	lumber or Run	Route Number, Ci	ty or Town, State, Zi	o Code)
	1 and Health tem 27 other tr		20a. Method of Disposition	(Luighter)	Place of Disposition (I	TTYSOL Name of	ing v	Date 20c	Location - City or T	own, State
Baltimore,	Pages ment of ent: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crematory c CCNM/WH	Cremati	u 5-1	1-04	Balto.	$m\Lambda$
Balt	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License	H	22. Name	and Address	Ficility Va	ughn CE	veeno Fu	neasus
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the deal	th. Do not enter the m	node of dying, su	ch as cardiac o	or respiratory arrest,	rug Gron	proximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Pre	arracton rie	umonia				Interval Between Onset and Death 5 days
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	ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a conseq	-					V
o,	te be executed ysician and e burial-transit	Examlner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	quence of):					
68760,		dlcal	d							
Box 6	h certifi ending use as	ın/Me	230. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		pregnancy			23d. Date of deliv	ery
P.O. B	he deat / the att ched fo	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d					Month	Day Year
s, P.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	g cause given in	Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
ord	w requir been si should	eted						1 Tes		
Division of Vital Records,	The law te has page 2 :	Completed						24a. Was an autopsy performed	prior to co	psy findings available impletion of cause of
Vital	vician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Place of Death	Check on one	10 10 105	2(1)140
Jol	Attending Physician: or death. ector: After this certifically the funeral director.	n: To	27. Mangrer of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at		ne 5 Residence 28d. Describe how in	6 ☐Other (Specification)	(y)
sior	tending F Jeath. tor: After the funer	catlo	1 Valural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury M	Work? 1 ☐ Yes				
Divi	el or Attenos s after death il Director: od in by the	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact	ory, office		City or Town, St	and Number or Rura ate)	M Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 € Certifying Phys (Check only one)	ician: To the best of my knowner: On the basis of examina	owledge, death occurr ation and/or investigati	ed at the time, da	ite and place, a	and due to the cause ed at the time, date a	o(s) and manner as s and place, and due to	tated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. License num		1	Date signed (Month,	
			P Kulph-,	7D		D00	52866	/	April 29,	2004
	4		30. Name and address of person who could have a sins	npleted cause of death (Item	n 23a) (Type, Print) 201	+ Unive	vsi	Parkwey	, Baltimer	many and
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		,			4.44	

			1 10400	State of Maryland					
			1 - For State Registrar	State of Marylant		te of Death	Reg. N	4004	14889
	Dhyoici	3.	1. Decedent's Name (First, Middle, L.	ist)			2. Date of Death	ay Year	3. Time of Death
	Physici /Medio		camuel V.	Burton,			MAY 5	7 2004	1515Has
	Examir	er	4a. Facility Name (If not institution, gi	PALTH CARE		, Town, or Location of Death	′ ′	c. County of Deeth	
	Funeral	1.70 m		Sex, 7. Age (In yrs. la		ALTIMORE or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Pay, Yea	9. Birthp	lace (State or Foreign
e la	Director		237-62-2447	M 20 F 63	Yrs.	Days Hours Min.	3-6-2	Cour	NC NC
1	No.		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location			1	0d. Inside City Limits
2	a-fsh illind	ctor	MD NA		Balti	more			1 Yes 2 No
i	Or 28	Dire	10e. Street and Number	1-1-1-1-1	10f. Z	p Code	10g. C	itizen of What Cour	ntry?
4	within 72 nouts atten beath with the maryland ene. Than "natural", or (tems 23a or 28a-f show the Moulcal Exemiter for all be notified at	erai	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. Was Dec	2/20 /	ecify Yes or No-	14. Race - Americ	an Indian
9	or Iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give	_	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
003	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1 Tes			Specify: B	4CK
15-	n /2 in	ojete	15. Decedent's E (Specify only highest gi	ade completed)	16a. Decedent's Us (Give kind of w life. QO NOT	ual Occupation ork done during most of work use retired)	ing 16b.	Kind of Business/Ind	dustry
21215-0036	De filed within 72 hours after death with the marylat had Hygiene. Ad other than "natural", or liems 23a or 28a-f show event. Its Maldical Exeminer mast be notified at	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5+)	Can	USTOR	K	ehabilita	tion
	itat Hygie d other event.	Be	17. Father's Name (First, Middle, Las	")		, , , , , , , , , , , , , , , , , , ,	(First, Middle, Maide	n Sumame)	
Maryland	s should be fried withing and Mental Hygiene.	2	19a. Informant's Name/Relationship	Of ( Type Print)	19h Mailing Addres	is (Street and Number or Run	e L'Onen	or Town State Zin	Codel
	2 € Z = Z		Cotherine Burton	(WIFE)	5514 Lit	perty Heights	AN BOH	imi)re M	10 21209
ore,	ges lan t of Heal If item 2 or other		20a. Method of Disposition  1 Burial 2 Cremation 3		ace of Disposition (Na emetery, crematory or	ime of other place)	Date 20c.	Location - City or To	1
	permit. Pages Department of I Important: If it any injury or o		'4 □Donation 5 □ Other (Spec	(y) VV(	edlawn (	emetery 5.13	1-04 BC	attimore	mo ·
Bal	permit. Fag Department Important: any injury o		21. Signature of Funeral Service Lice	asee	22. Name a	Address of Facility Wou	yn Car	ene Funer	al Derme
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	applications that caused the death	. Do not enter the mo	de of dying, such as cardiac	or respiratory arrest,	Oldwid T	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition		HOMA				Onset and Death
(2.85)	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):				10 11
m /	100	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Jue to (or as a consequ	ance ofy:				
/	nd	Examiner	that initiated events	c.					
760,	are be executed lysician and he burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):				
687	Firstciant: The law requires that the death definicate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	edicai		d					
Вох	eath cermican attending phy I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar				23d. Date of delive	ry
. B	he atte	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of de				Month	Day Year
P.O.	natine de led by the a detached f		Part II. Other significant conditions	contributing to death but not resu	Iting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
of Vital Records,	quires ina n signed ald be det	Completed by	CONGESTIVE	CARDIAC !			1 ☐ Yes	No 3 □ Proba	ably 4 Unknown
000	has been ge 2 should	piet	CORONARY	ARTERY OL	SEASE		24a. Was an autopsy	24b. Were autop	osy findings available inpletion of cause of
H =	certificate ha	Com					performed? 1  Yes 2 N	death?	20 No
Vita	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	(Check only one)		
o o	eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3□ D 28b. Time of	28c. Injury at	me 5 Residence 28d. Describe how inju		")
ion	ath. or: Atte	atio	1 Natural 5 Pending 2 Accident Investigation		Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division	fter de Sirecto in by t	Certification:	3 ☐ Suicide 6 ☐ Could not determined		me, farm, street, facto	ry, office	28f. Location (Street a City or Town, Sta	ind Number or Rurai te)	Route Number,
	To the nospital or Attending Fill within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying P	hysician: To the best of my know	vledge, death occurred	d at the time, date and place.	and due to the cause(	s) and manner as st	ated.
3	ne no n 24 h he Fur pletely	Medical	(Check only 2 Medical Exa	miner: On the basis of examinati and manner stated.	ion and/or investigatio	n, in my opinion, death occurr	ed at the time, date ar	nd place, and due to	the cause(s)
,	Within To t	Σ	29b. Signature and title of certifier	A	29	O. License number		ate signed (Month, L	
	0		30. Name and address of person wh	I I) an	22a) (Type Briet)	P16693	CATTA	7 09 20	004
			DR - SARUM	ST AGNE		TAZ BAJI	IMORE, I	40 212	29.
15	Sta Registi		31. Date fill A Yith Day Y 2004	2. Registrar's Signat		<b>.</b>			

BURTON

SAMUEL

			_ For	State of Marylai	nd / Departme	ent of Healt	h and Me	ntal Hygiene	)	
			1 - State Registrar		Certifica	ate of Dea		Reg. No	. 2001	11890
	Physici	an	Decedent's Name (First, Middle, Last				2.	Date of Death Month Da	y Yeer	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give	street and number)	4h Ci	ty, Town, or Locati		May 9	2004 County of Deetl	1 8:03PM
	Examir	ier	University of Mary	1 1 1 1		Pa	Himer	9	NIA	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs			nder 24 Hrs. 8.	Date of Birth (Month, Day, Year)	9. Birtl	hplace (State or Foreign
13	Director		48060284	M 2 € F	2 Yrs.	IS Days 1100	IVIIII.	10/19/19-	H	MD
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location					10d. Inside City Limits
	Mary	to	MD NA		BALTIM	DRC				1 XYes 2 □ No
	or 28s	Funeral Director	10e. Street and Number		1	Zip Code		10g. Ci	tizen of What Co	untry?
	ath wi	ral	3530 WHITE C			212			USA	
	lter de	-une	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 X No	J.S. 13. Was De If Yes, s	cedent of Hispanic pecify Cuban, Mex	: Origin? (Specif cican, Pu <i>e</i> rto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	
920	urs af	b	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 No Spec	city:		Specify: B	LACK
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie marked other than "natural", or Items 23a or 28a-f ehow important: If item 27 ie marked other than "natural", or Items 23a or 28a-f ehow important; or Items 23a or 28a-f ehow important in items of the marked and included at page.	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's U (Give kind of	work done during r	most of working	16b. K	(ind of Business/l	Industry
121	within ane. than	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	EARLY CH	,	Salar S	149017	HEADST	-AOT
о 5	should be filed within of Mental Hygiene. marked other than imatic event, ine M	e Co	2th Grade 17. Father's Name (First, Middle, Last)	layrs.	PARCY CH			irst, Middle, Maider		TRI
<u>la</u> n	Aental rked o	To Be	JAMES ROBER	LTS		L	CILA T	BROWN		
lary	2 should and Men ie marke aumatic		19a. Informant's Name/Relationship (T)		19b. Mailing Addre			oute Number, City	or Town, State, Z	(ip Code)
	and lealth m 27		CHARLES BROW	· · · · · · · · · · · · · · · · · · ·	3530 V	the second second second	APEL RI	AD BALT		
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1 Burial 2 Cremation 3 F	Removal from State	cemetery, crematory of	r other place)			ocation - City or 1	
Ħ	permit. Pages Department of I Important: If ite eny injury or of		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signalure of Funeral Service Livers</li> </ul>		ARBUTUS 22. Name			104 BA		
Ba	Depa Impo		Vand (		VAU	SHN C. (	3REENE 2R NATI	DNAL PIKE	BALTIN	2VICES 10RE MD 21229
			23a. Part1. Enter the disease, or comp shock, of hear failure. List only o	ications that caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	seds'i	5					Onset and Death
п	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
		er	if any, leading to immediate	b. Due to (or as a conse	quence of):					
	outed id ansit	Examiner	Cause (Disease or injury	c						
Ö,	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as a conse	quence of):					
8760,		dlcal		d						
9 x	death certifica e attending ph ed for use as the	Physiclan/Med	IF FEMALE:	23c. If yes, outcome of pregn	nancy				23d. Date of deli	wan.
Вох	death a atten d for u	iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live birth 2 ☐ Fet 4 Pregnant at time of	al death 3 ☐Ectopic				Month Month	Day Year
P.O.	t the c by the tached	hys	9 Unknown	9□ Unknown						
	The law requires that the deate has been signed by the a bage 2 should be detached to	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlyin	g cause given in Pa	art I.		_	the cause of death?
Records,	w requir been si should	Completed						1 ☐ Yes 2	No 3 Pro	bably 4 Monknown
3ec	has b	mpje						24a. Was an autopsy performed?	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
a	n: Th ficate or. pag		25. Was case referred to medical					1 Yes 2 No		2 □ No
<u>=</u>	Physician: r this certificantal director.	To Be	examiner?	Hospital: 1- Inpatient 2	]ER/Outpatient 3□	Other	lace of Death (C	5 Residence	6 Cother (Sner	ife)
סר	ig Phy ter thi neral o	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		. Describe how intu		iny)
Siol	Attending r death.	catic	1. ■Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		М	1 □ Yes 2	R□No			
Division of Vital	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At It building, etc. (Special	nome, farm, street, fact ify)	ory, office	28f.	Location (Street are City or Town, State		ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier PCertifying Phy	sician: To the best of my kn	owiedge, death occurr	ed at the time, date	e and place, and	due to the cause(s	and manner as	stated.
	n 24 h	edical	(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.	ation and/or investigati	on, in my opinion,	death occurred	at the time, date and	place, and due	to the cause(s)
	To the state of th	Σ	29b. Signature and title of certifier	11		29c. License numb		29d. Da	te signed (Month	, Day, Year)
•	6		11/1/8mg	MIT		M1445	2	PL	47,2	7
	9		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type, Print)	h Caspel	ne St	reet F	2 Him	ore, MD
	Sta	ate	31. Dete filed (Month, Day, Year)	32. Registrar's Sign		· I OICO	1 01	) 1	المرا المرا	
	Renist	rar	11111 1 1 2004	Selver L						

			1 - State Amend Item 8		15-05 15-05 <i>Cer</i>	tas tas tificate of	lealth and N Death		3	14891
	Physici		1. Decedent's Name (First, Middle, Last Bobby Birch					2, Date of Dea Month	Day Y	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	April 2	26, 2004 4c. County of I	9:25 P
		•	12208 Fleming Lan	е		Bowie			Prince	Georges
	Funeral Director		370-40-7810	7. Age (In yrs. In 1985) 7. Age (In yrs. In yrs. In 1985) 7. Age (In yrs. In yrs. In yrs. In yrs. In 1985) 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3-31-19	(Year) 9.	Birthplece (State or Foreign Country) Georgia
	and		Usuel Residence of Decedent  10a. State  10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sho	ţŏ		Wash	ingtor	n, D. C.				1 Yes 2 No
	or 28s	Jirec	10e. Street and Number	37 77		10f. Zip Code			log. Citizen of Wha	•
	sath w	srai	3412 Warder Street		10.1	20010	0.5-1-0.70		U. S. A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Exempres must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ul> <li>12. Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:</li> </ul>	11	Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecry Yes or No- Rican, etc.)		American Indian, White, etc. Black
200	72 hou natura	eted	15. Decedeni's Edu (Specify only highest grad	cation e completed)	16a. Deced	lent's Usual Occup	ation during most of work	ring	16b. Kind of Busin	
2121	d within giene. or then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	Corp of E	1)		Federal (	Government
Baltimore, Maryland 21215-0036	uld be file fental Hyg rked othe fic event,	To Be C	17. Father's Name (First, Middle, Last) Robert Birch				18. Mother's Name Bessie		Meiden Sumame)	
Mary	d 2 shouth and N is and N is main treumal		19a. Informant's Name/Relationship (7) Celestine Allen Bi				and Number or Run		-	
re,	s 1 and Heal		20a. Method of Disposition		ace of Dispos	Natuer St sition (Name of natory or other place	reet, NW		20c. Location - City	
<u><u>E</u></u>	Page ment o ant: If ury or		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from State	ncoln	Memorial		1, 2004	Suitland	, Maryland
Balt	permit. Departimport Import any inj		21. Signature of Funeral Service kicens	llanes			ss of Facility La Sia Ave. I			ne DC 20011
-			23a Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the death ne cause on each line.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
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4	₽ ≅	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					
	and A-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					-
68760,	ificate be executed g physician and as the burial-transit			1.						
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.O. Box	The law requires that the death certifute has been signed by the attending vage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
s, P	res that tigned by	þ	Part II. Other significant conditions con	ntributing to death but not resu	lting in the un	derlying cause give	en in Part I.			te to the cause of death?
orc	w require been si should I	eted						-		Probably 4 Winknown
Vital Record	The law cate has page 2 s	Completed						24a. Was a autops perform	y prior ned? deat	autopsy findings available to completion of cause of h? Yes 2 \sum No
Zit;	sician: The certiticate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital:	0/0	3C DOA Othe	26. Place of Death			
on of	Attending Physician: or death. ector: After this certific by the funeral director.	lon: To	27. Manner of Death 1 ☐Natural 5 ☐ Pending		R/Outpatient 28b. Time of Injury	28c. Injury Work	at		ence 6 Other (S w injury occurred	Specify)
Division of	2 m in c	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre		Yes 2□No	28f. Location (St. City or Town	reet and Number o. n, State)	r Rural Route Number,
	To the Hospitel of within 24 hours at To the Funeral D completely filled it	edicai (	29a. Certifier (Check only one)  1  Certifying Phy 2  Medicel Exemi	sician: To the best of my knowner: On the basis of examinati and manner stated.	rledge, death on and/or inv	occurred at the time estigation, in my op	e, date and place, pinion, death occurr	and due to the cared at the time, da	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To the To the comp	¥	29b. Signature and title of certifier		0	29c. License		2:	9d. Date signed (M	onth, Dey, Year)
•	1		18880	1) /a	lle		075	•	1/30/	04
	6		30-Name and address of person who co Shabua Malik, MD	mpleted cause of death (Item 3800 Resevoi:			rton D C	20007	1	/
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure		scon, D.C	. 20007		
	Registr	ar	MAY 1 1 200	14	& Box	and I				

			1 - For State Registrar	State of Maryl	and / Depa	artment of F	lealth and I Death	Mental Hy	giene Reg. No. 20	004 1489
	nysicia Medic		1. Decedent's Name (First, Middle, Last, JACOB WII	LIAM	BONNET	T JR.		2. Date of De Month MAY O	Day	Year 9:45 A M
E	xamin		4a. Facility Name (If not institution, give 7926 WEST END DR 5. Social Security Number 6. Second	IVE	yrs. last birthday)	4b. City, Town, o  Baltimo	r Location of Death TE			ARUNDEL CO.
Dir	neral ector		213-32-9042 15 Usual Residence of Decedent	QM 2□F	68 Yrs.	Months Days	Hours Min.	July 0	y, Year) 4 1935	9. Birthplace (State or Foreign Country) Maryland
ith the Marylan	on notified at	Director	10e. Street and Number	ındel Co.	City, Town or Lo	more 10f. Zip Code	200		10g. Citizen of W	
5-0036 72 hours after death with the Maryland	the Medical Exemper must be notified at	by Funeral Director	7926 West End Dr  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	1Ve  12. Was Decedent Ever i Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		212 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No o Rican, etc.)		S.A American Indian, c, White, etc. white
Maryland 21215-0036  nd 2 should be filed within 72 hours aff filth and Mental Hygiene.	the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor <sup>[]</sup> Superint sportatio	n		Baltimore
aryland should be file	other traumatic event,	To Be		Bonnett Sr			Irene		Sweder	
	ther traum	1 1	Joan F. Bonnett  20a. Method of Disposition	(Wife)		ng Address (Street  West End			re, Md.	
Baltimore, permit. Pages 1 a Department of Hea	njury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Glen Hav	en Mem. F	ark 05/1	2/04	Glen Bu	rnie, Md.
Ba Depa	any ii		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or compl	2 censor	W	Name and Address McCully 237 E.	Patansco	Ave. Ba	altimore	P.A. , Md. 21225 Approximate
8760, ale be executed the project and the second an	dical	dical Examiner	shock, or heart failure. List only of the control o	Due to (or as a con	sequence of):  Left Messequence of):  Muyrxu	- Cendio ( Oli fus Stry Lure	Vascular	Dise	are	Interval Between Onset and Death
	for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery h Day Year
	a d	ρχ	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.			bute to the cause of death?
E all	page 2	Completed						24a. Was autop perfor 1 Yes	rmed? de	ere autopsy findings available ior to completion of cause of lath?
o a a	funeral di	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	28c. Injun Work	4   Nursing H	ome 5 9 esid	ne) lence 6 □Othe low injury occurre	
= a = a	completely filled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury · A building, etc. (Sp.	At home, farm, str ecify)	eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
To the Hospitel or within 24 hours after To the Eugenel Director	pletely fill	Medical	one) 2 Medical Exami	sician: To the best of my ner: On the basis of examand manner stated.	knowledge, death nination and/or inv	estigation, in my op	pinion, death occur	and due to the cred at the time, o	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
Twith	5 /	2	29b. Signature and title of certifier	Buju A	LD,	29c. License	0 = 0		-	(Month, Day, Year) 10 / 2004
В	Sta egistra		30. Name and address of person who co Christopher 31. Date filed (Month, Day, Year) MAY 1 1 2004	ampleted cause of death (	370	8 MOU Spocks	tian R	d Pas	sadena	,MD,21122

		For State	State of Marylar	-	artment of H	ealth and N		ne	11.000		
	_	Registrar  1. Decedent's Name (First, Middle, Last	3	Ce	rtificate of L	Death	Reg.	No. 2001	3. Time of Death		
Physici							Month	Day Year	м		
/Medi Examir		Harriet Bergqui 4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	May 5,	2004 4c. County of Dea	19:30 P		
		Morningside Ass			Ellicott	City		Howard			
Funeral Director		5. Social Security Number 6. Se 1	7. Age (In yrs. 95	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)		
		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo			Jan.1,	1909 MI	10d Inside Co. It is		
Maryla f sho	ior								10d. Inside City Limits 1 ☐ Yes 🎖 🛱 No		
n 28e-	irect	MD Howard  10e. Street and Number	EII	icott	City 10f. Zip Code		10g.	Citizen of What Co			
ath wit	Funeral Director	5330 Dorsey Hal						USA			
ter des Items	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 No	.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
al', or	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 💥 No	Specify:		Specify:wh:	ite		
72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occupa kind of work done d	lurina most of work	ring 16t	b. Kind of Business	/Industry		
within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	Homem	DO NOT use retired)	)		un Homo			
be filed within 72 hours after death with the Maryla lat Hyglene. d other than "natural; or items 23e or 28e-f sho event, the Madical Examinatment be notified at	Be C	17. Father's Name (First, Middle, Last)		nomem	aver	18. Mother's Nam	e (First, Middle, Mai	WN_Home  den Sumame			
Lat y failed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural, or Items 23e or 28e-f show aumatic event. It is Madical Examinating must be notified at	ToE	Lars Pederson					Jacobso				
ges 1 and 2 should to f Health and Men i if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (T) Sharon Sadler/d					a <i>l Route Number, C.</i> Ellicott	-	Zip Code) Ad. 21042		
permit. Pages 1 and: Department of Health Important; If item 27 any injury or other tr	L	20a. Method of Disposition	20b. I		esition (Name of matory or other place			c. Location - City or			
nit. Pages artment of I ortant: If ite injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ The '4 ☐ Donation 5 ☐ Other (Specify)					/2004 <sub>Re</sub>	dwing.	Minnesota		
permit. Departimport. any inj		21. Signature of Funeral Service Licens		1 2	2. Name and Addres	s of FacilityWit	zke Fun	eral Hor	nes, Inc.		
9 403 40		23a. Part1. Enter the disease, or ampl	ications that caused the deal						1d. 21045 Approximate		
Physician		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.  ADVAVO		EMENTIA	,,			Interval Between Onset and Death		
/Medical		disease or condition resulting in death)	Due to (or as a consec		CMENTIA				GE ANS		
Examiner	-	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying	Due to for as a consec	userov ville							
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):									
가 수 등	dical		d								
death certificate at the use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna			23d. Date of del	iverv				
death death death death	siciai	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year		
res that the de igned by the a be detached f	Phys	9 Unknown		uulkimmi in kkon u		a in Dani I	220 Did tohoo	Did tabasas usa satisfasta ta the same of death of			
uires ti signe	d by	Prairie of the significant containons contributing to death but not resulting in the underlying cause given in Part i.							acco use contribute to the cause of death?  s 2 No 3 Probably 4 Unknown		
sw require s been slg	olete						24a. Was an	24b. Were au	itopsy findings available		
The lav	Completed						autopsy performed 1 Yes 2	i? <u>L</u> death?	completion of cause of 2 \( \subseteq \text{No} \)		
Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical an experiment? 26. Place of Death (Check only one)									
Phys or this	To :	1 Yes 2 No	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	nt 3□ DOA Outle f 28c. Injury Work	" 4 ☐ Nursing Ho	me 5 Residence		THE CIVING		
tending leath.  tor; After the funer	atlor	1  Natural 5  Pending 2  Accident investigation	(Month, Day Year)	Injury		? ′es 2 □ No					
or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str by)	eet, factory, office		28f. Location (Stree City or Town, S		iral Route Number,		
spital ours as seral D		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, deat	n occurred at the time	e date and place	and due to the caus	e(s) and manner as	stated		
To the Hospital or Attending within 24 hours after death. To the Funeral Director, After completely filed in by the fune	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my op	inion, death occur	red at the time, date	and place, and due	to the cause(s)		
To the To the Complex	Σ	29b. Signature and title of certifier			29c. License		29d.	Date signed (Monti	h, Day, Year)		
1		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) /T	D5	1860	•	124 6,	2004		
\		BWANTAN FIGH A		MATEN	Paire #	200 Coc	undia m	n croyy			
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	PAINE #						
Regist	al	MAY 1 1 2004 X	Temporal Co	apa	de						

401/10/10		1 - State Amend Item 23a per Dr., G831, 05/11/04dbbertificate of Death  1. Decedent's Name (First, Middle, Last)								Reg. No. 2004 2. Date of Death Month Day Year 3. Tim				3. Time of Death
Physici /Medic Examin		Carolyn V	. Bosch							May	3,		004	5:55 a
		4a. Facility Name (If not institution,	-	ber)			City, Town, or Location of Death				4c. County of Deeth			
		Laurel Regional		2 4 // /	t fall do d	La If Under	urel	If Under	24 Ure	0.0		rince		-
uneral rector		5. Social Security Number 211-01-4523	6. Sex 7 1  M 2  F 7	7. Age (In yrs. last 85	Yrs.	Months	Days	Hours	Min.	8. Date of 8				ace (State or Forei try)
ctor		Usual Residence of Decedent	AA	0.5						Aug 1	1, 1	918	Pen	nsylvania
4		10a. State 10b. County	-	10c. City, T	own or Lo	cation					10d. Inside City Limit			
Illian	ctor	MD Princ	ce George'	s La	aurel							1 ☐ Yes		
20	Director	10e. Street and Number 10f. Zip Code								10g. C	0g. Citizen of What Country?			
TST.	Funeral	13149 Larchdale				20707						U.S.A.		
be lied within 72 hours after beaut with the maryland tall Hygiene. Ad other than "natural", or items 23a or 28e-f ehow event, the Medical Examinating to notified at		11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	Armed Fore		13. \	Was Deced If Yes, spec	lent of His city Cubar	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or I Rican, etc.)	No-		- Amenc c, White,	
zam	by F	3∑ Widowed 4 □ Divorced	If Yes, Give	d 1 ∐ Yes 2 XXNo If Yes, Give Year or Dates:		1 ☐ Yes 2	2 <b>X</b> No	Specify:				Specify:		nite
#	ted	15. Decedent's	s Education	1	dent's Usual Occupation				16b.	Kind of Bus				
Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-	4or 5+)	life.	kind of wor DO NOT us	rk done d se retired)	uring mos )	t of worki	ing				
5	No.	Grade 8			Hou	sewif	е				(	Own Home		
umatic event	Be	17. Father's Name (First, Middle, L.	ast)							, ,	lle, Maide	laiden Sumame)		
	ပို	Wm. K. Barnhart		_						Garris				
raun	1	19a. Informant's Name/Relationshi		1						al Route Nun				Code)
Department of Health and Mer Importent: If item 27 is marke any injury or other traumatic once.		Carol Sisson /	Grandch			9 Lar				Laurel, Maryland 20708  Date 20c. Location - City or Town, Stete				
		1 Burial 2 Cremation		State 1			ition (Name of atory or other place)  Date 20c. Location City or Town, Si 20c. Seanor Ch. Cem. 5/7/04 Hempfield, PA							
injury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		St. P							-		eld,	PA
any i		(13 St	, CO11300	/ M00770	,	Donal	dson	Fune	ral	Home,	P.A.			00505
		23a. Part1. Enter the disease, or c	complications that ca	*		er the mode	e of dying	, such as	cardiac c	Lau	arrest,	Mary.	Land	20707 Approximate Interval Between
ysician	3.5	Immediate Cause (Final Onset and Deat Congestive Heart, Failure												
dical	Immediate Cause (Final disease or condition resulting in death)													
iner			Acute Renal Failure											
			Ac			ilure								
	ner	Sequentially list conditions,	D		l Fa	ilure								
transit	aminer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c	eute Rena or as a consequen	l Fa	ilure								
ourial-transit	I Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	ute Rena	l Fa	ilure								
the burial-transit	cal	that initiated events	Due to (c	eute Rena or as a consequen	l Fa	ilure								
ise as the burial-transit	edical	resulting in death) Last	cDue to (c)d	eute Rena or as a consequen	al Fa	ilure			21			23d Date	a of delive	D.
for use as the	edical	resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	eute Rena or as a consequen	al Faince of ):	ilure			Ē			23d. Date Mont		ry Day Year
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	•	For State Registrar	State of Marylan	d / Depa	artmei		h and N	lental Hyg		200		+895	
Physici	an	1. Decedent's Name (First, Middle, Last) Paul Edward	Boone					2. Date of Dea Month	th Day 200	Year		of Death	
/Medic	al	Paul Edward  4a. Facility Name (If not institution, give s							County of Dee		:53 A <sup>M</sup>		
Examir	ıer	5800 Windsor Mill				ltimore				altimor			
Funeral Director		5. Social Security Number 6. Sex 238-46-8491		last birthday) Yrs.	) If Under Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day JUNE 6,	, Year)	C	thplece (State country) th Car		
permit. Pages 1 and 2 should be filed within 72 hours after death with the maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ehow any injury or other traumatic event, it a Medical Examinar man be notified at ance.	ĭo	Usual Residence of Decedent  10a. State  10b. County		y, Town or Lo								City Limits	
	Directo	Maryland Baltimore Baltimore  10e. Street and Number 10f. Zip Code 10g. Citizen of								izen of What Co	ountry?		
23a o		5800 Windsor Mill	Road #2-B			207			USA				
, or items	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Noticed	<ul> <li>12. Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:</li> </ul>		Was Dec If Yes, sp		c Origin? (Sp xican, Puerto ecify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whi Specify:			
n "natural Nedical Ex	Completed b	15. Decedent's Edu (Specify only highest grade	cation	(Give	e kind of w	ual Occupation ork done during use retired)	most of work	ang	16b. K	ind of Business	/Industry		
giene er tha	E O	Elementary/Secondary (0-12) 12	College (1-401 5+)	Brick	klaye					structi	on		
a Hy	Be	17. Father's Name (First, Middle, Last)				18. N	Nother's Nam	e (First, Middle,	Maiden	Sumame)			
Ments Arked arked	2	Amnor, Van Boone		Norma  19b. Mailing Address (Street and Number of				Jean Gee					
th and		19a. Informant's Name/Relationship (Ty Paulette Cunningh							_	timore.		2120	
I. Pages 1 and the strain of Healt riant: If item 2 njury or other		20a. Method of Disposition	20b. Place of Disposition (Name of Date							ocation - City or			
		1 Burial 2 Cremation 3 F	Metro Crematory Inc. 5-8					3-04 Baltimore			MD		
Depa Impo any i		21. Signature 1. negal Service Licen  Edward A. Gr		(	Crema	tion So rederic	ciéty k Road	of MD, ]	Inc.	e, MD	21228		
hysician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the deat e cause on each line.  Metastati	or respiratory ari	rest,	,	Approxir Interval	nate Between nd Death					
death centricate be executed  Exam  e attending physician and od for use as the burial-transit		resulting in death)	Due to (or as a conseq	juence of):		3311002							
	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).										
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of de Month	olivery Day	Year	
6 5 8	Ď	Part II. Other significant conditions con Cachexia, Gait	intributing to death but not resulting in the underlying cause given in Part I. $\operatorname{Disorder}$					23e. Did to	tobacco use contribute to the cause of de Yes 2xxNo 3 ☐ Probably 4 ☐Ur				
ate h page	Completed	24a. V a p								24b. Were autopsy findings available prior to completion of cause death? 2 No 1 Yes 2 No			
rnysician: in this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitat:			Other		th Check on o		. 500 10			
ang ruys h. After this funeral div	lon; To	27. Manper of Death 12. Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 No.						lome 5  Residence 6 □ Other (Specify)  28d. Describe how injury occurred					
To the Hospital or Attending Fill within 24 hours after death.  To the Funeral Director: After the completely tilled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Lo								8f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the hospital or Attention within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier Check only one) Certifying Phy	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, dea ation and/or i	ath occurre investigati	ed at the time, da	ite and place n, death occu	, and due to the c rred at the time, c	cause(s date an	) and manner a d place, and du	s stated. e to the caus	ie(s)	
within To the	Re	29b. Signature and the of certifier	1)-11.	, 11	10 2	9c. License nun	nber		29d. Da	te signed (Mon	th, Day, Yea	r)	
0		Cellen	Keill	1/11		D54749			May	7 200	)4		
0		30. Name and address of person who c	ompleted cause of de	m 23a) (Type	e, Print)								
		Allen Reilly, MD	4805_Renso	n Aver	nue	Raltim	ore, M	D	21	227			
St Regis	ate	MAY 1 1 2004	5 negistrar's sign	6	Son	del.							

			Please 1	Type or Prin							-		
			State of Maryland / Department of Health and Certificate of Death						Reg. No. 2004 14896				
	Physici		1. Decedent's Name (First, Middle, Last)  Jean M. Buttion						2. Date of De Month	Dar 5	y Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4	b. City, Town, c	r Location of Death		4	. County of Dea		
			Franklin Square Hospital Rosedale							B		nose	
	Funeral Director		218 22 8916	x 7. Age ☐ M 2 🔯 F	75		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 8/12/	th ay, Year) 1928	9. Bin	thplace (State or Foreign untry)	
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town		tion					10d. Inside City Limits	
	e Man	ctor	MD Baltimo	re	Rosed	lale						1 ☐ Yes 2 XNo	
	be filed within 72 hours after death with the Maryland hal hygiene. ad other than "neturel", or Items 23a or 28e-1 show event, I're Mcdical Examinar rust be notified at	Funeral Director	100. Street and Number 101. Zip Code 21237							10g. Cit	izen of What Co USA	ountry?	
	er dea	uner	11. Marital Status 12. Was Decedent Ever Armed Forces?			If Yes, specify Cuban, Mexican, Puerto				0-	14. Race - American Indian, Black, White, etc.		
0036	urel', or l	Completed by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specification of the State of State of Specification of the State of State of Specification of the State of S					Specify:			Specify: White		
15	in 72 t	olete	15. Decedent's Edi (Specify only highest grad	+) 16a.	(Give kir	it's Usual Occup id of work done NOT use retire	during most of work	ring	16b. K	ind of Business	Industry		
212	giene. grene. er tha.	Com	Elementary/Secondary (0-12)	or			Tele	ю.					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumatic event, Ite Medical Examinet must be notified at once.	To Be (	17. Father's Name (First, Middle, Last) Linwood Palmer	17. Father's Name (First, Middle, Last) 18. Mothe						, Maiden edfor	Sumame) Cd		
	nd 2 sho alth and h 27 Is ma ir treuma		19a. Informant's Name/Relationship (7 Lawrence Joseph		19b.	Mailing LOO8	Address <i>(Street</i> Chesaco	and Number or Rur Avenue R	ai Route Numb Rosedale	er, city o	r Town, State, 2 cyland 2	Zip Code) 21237	
	Pages 1 a ent of Hea nt: If item ry or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,	20b. Place of Disposition (Name of Date   Coemeign, crematory of their place)  □ Removal from State   Gardens Of Faith   05/08/(							c. Location - City or Town, State Aspeburg Maryland		
	permit. F Departm Importar eny injur		21. Signature of Funeral Service Licens	ss of Facility Cva aco Avenue	ach/Ros	al Home							
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do r						Maryran	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	501/00	- 0	OP	$\bigcirc$					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	consequence	of):	1 20 -						
	-6.3	er	Sequentially list conditions, if any, backing to humboliate cause. Enter Underlying Cause (Disease or injury	5. 11570 (or each	S nonsaquence :	on PC	imo	nary	1 15				
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	EX	20545	e							
,09	sician a												
687	tificate ng phys as the	Medic		d									
Box	es that the death certificate igned by the attending physbe detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No	23c. If yes, outcome of the community of	2 🗌 Fetal death		topic pregnancy	,			23d. Date of del Month	ivery Day Year	
P.0.	at the d by the	Phys	9 □ Unknown *	9□Unknown					15				
Vital Records,	The law requires that ate has been signed b bage 2 should be deta	ed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa						23e. Did tobacco use contribute to the cause			obably 4 Unknown	
ecc	e law re has be ge 2 sho	Completed							24a. Was	psy	prior to o	topsy findings available completion of cause of	
a B	iù								1 Tes	performed? death?  1 Yes 2 No 1 Yes 2 No			
	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2 ER/Ou	itnatient	3□ DOA Oth	er: 4 ☐ Nursing Ho			6 ∏Other /Sner	rifu)	
n of			27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. T	Fime of	28c. Injur Wor	y at	28d. Describe			Jily /	
Division	Attending r death. ector: After by the fune	icatle	2 Accident investigation 3 Suicide 6 Could not be	On Disease file	At h fo			Yes 2 □No	OPE Laurtine	· Ca			
DİX	tal or Attenders after deatles after deatles birector: ed in by the	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plant occurred at the time, date and the tim							, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the o			
	To the within To the comp	M	29b. Signature and title of certifier				29c. Licens				e signed (Month	n, Day, Year)	
•	3		30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (	(Type, Pri							
	1		Dr. Arif Sheik	h 9000	Fran	klir	Sque	IR Driv	e Bal	tim	ore, M	D 21237	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 1 2004	32. Registra	rs Signature	180					,		
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		ľ	For State Registrar	State of Mary	-	artment of F rtificate of			iene eg. No. 2 N N I	1. 11.007
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat	h	3. Time of Death
×	Physici /Medio Examir	al	LILIAN 4a. Facility Name (If not institution, giv.	e street and number)	CO	LON 4b. City, Town, o	or Location of Death	Mary	Day Yea  2 200  4c. County of De	4 11:50 P M
1			Frederick Memoria			Frederic	o k		Frederi	
	Funeral		5. Social Security Number 6. S	ex 7. Age (in	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	□M <b>2CX</b> 72	Yrs.	Months Days	Hours Min.	11/24/		erto Rico
	Marylan a-f ehow	ctor	MD Montgom	1	c. City, Town or Lo Wheato					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28 ist be no	al Dire	10e. Street and Number 4011 Randolp	h Rd.		10f. Zip Code 209 (	02		Og. Citizen of What (	Country?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow amy injury or other traumatic event, I'ns Madical Examinational motified at ances.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Ppivorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 2 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1⊠ Yes 2□ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify: Pue	ecify Yes or No- Rican, etc.) rto Ric	14. Race - An Black, Wh Can <sub>Specify:</sub> W	nerican Indian, lite, etc. hite
21215-0036	ithio 72 ho ne. nen "natu	npieted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	oation during most of work d)	ing	16b. Kind of Busines	,
2	led w lygier lygier lygier th	S	12	-		<u>Iomemak</u> e			Domesti	С
Maryland	ould be fi Mental H arkad otl atic ever	To Be	17. Father's Name (First, Middle, Last)  Juan Colon				Marie T		7ega	
, Mar	and 2 sh salth and n 27 is m ar traum		19a. Informant's Name/Relationship ( Ruth Lisser	Daughter	287	Chestnu	ıt Ave.		City or Town, State,	
Baltimore,	Pages 1 ent of He nt: if iten ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Ob. Place of Dispo cemetery, crei	sition (Name of matory or other place Leigh Ce			20c. Location - City of Camden ,	
Balti	permit. Page Department of Important: If any injury or Once.		21. Signature of Funeral Service Licen	see Victor P. Do	da, Jr. Cr.	Name and Addres	ss of Facility tevens Funer nt Avenue, I	ral Home,	Inc. MD 21220	
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Acule	Renal	er the mode of dyin	ng, such as cardiac			Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Gasto  Due to (or as a co	in testi	al BI	leeding			I week.
	ate be executed nysicien and he burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a cond.	nsequence of);					9
P.O. Box 68	The law requires that the death certificat attending phy attented been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	alivery Day Year
rds, P	quires that the de n signed by the a uld be detached f	ρλ	Part II. Other significant conditions of Advanced	Demen 179	t resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
		Completed						24a. Was an autopsy perform	prior to ed? death?	utopsy findings available completion of cause of
Vital	nysician: Th nis certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death		`	
o	Physical direction	2	1 ☐ Yes 2 No  27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. injury Work	y at k?	me 5 Resider 28d. Describe hov	nce 6 Other (Spewinjury occurred	ecify)
Division	Mospital or Attandi 24 hours after death. Funaral Diractor: A etely filled in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, str oecify)		Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or F State)	dural Route Number,
_	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune.	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the best of my niner: On the basis of exa- and manner stated.	knowledge, death	n occurred at the time vestigation, in my op	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
•	To th within To th comp.	Me	29b. Signature and title a certifier	4		29c. License		29	d. Date signed (Mon	th, Day, Year)
	N		30. Name and address of person who described Zu	-1- 110	(Item 23a) (Type,	Print) TOLL	House,	Are,	Frederick	K, MD 2170
	Sta Registr	. • .	31. Date filed (Month, Day, Year)  MAY 1 1 2004	82. Registrar's S	ignature	٠ ۵ ٠				,

			For State Registrar		State	of Marylan	d / Depa	artment o	of Hea	alth a eath	nd M		giene Reg. No. 2 (	004	148	398
	Physicia	'n	1. Decedent's Name			) -						2. Date of Dea Month 1	Day	Year	3. Time of D	
	/Medic	al	4a. Facility Name of			iar pe		4b. City, Tov	wn or Lo	ocation of	f Death	May 7	2004 4c. Count	y of Death	0310	M
	Examin	er	ucmc	TIOI WISINGTO	, g#0 3(/00! ±/0 //			45. 049, 10		el A			Harf		,	
	Funeral		5. Social Security No	umber	6. Sex	7. Age (In yrs.		If Under 1 Y Months D		f Under 2 Hours	4 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or try)	Foreign
v	Director		153-48-		1 □ M 2 🗹 F		50 Yrs.	Months	ays	Hours	TVIII I.	Oct 28		MD		
	and *		Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or Lo	ocation						1	0d. Inside City	Limits
	Marylis f sho	JO!	MD	Harf	ord	Ab	ingdor	1							1 ☐ Yes 2	
	n the Marylan r 28a-f show motified	rect	10e. Street and Nun	nber				10f. Zip Co	ode				10g. Citizen of	What Coun	try?	
	death with the Marylandins 23a or 28a-f show	ai D	1002 Cro	ss Lan	ıe			2100	9				United	d Stat	es	
98		by Funeral Director	11. Marital Status		ied Armed F	2 No	Į.	Was Decedent If Yes, specify		anic Orig Mexican, Specify:	in? (Spe Puerto I	cify Yes or No- Rican, etc.)	14. Ra Bla Speci		etc.	
7	72 hours "natural",		3 Widowed		t's Education	Dates:	16a. Dece	dent's Usual O	occupatio	on			16b. Kind of E	Whit Business/Inc		
32/0	be filed within 72 hours after tal Hygiene. d other than "natural", or its event, the Madical Examins	Completed	(Special Elementary/Second	ity only highe	st grade completed	(1-4or 5+)	(Give life.	kind of work of DO NOT use r	done duri retired)	ing most	of workii	ng	Health		,	
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5/7/04 altimore. Maryland	2 should be filed we and Mental Hygie is marked other traumatic event, in	o Be	17. Father's Name (			1:						(First, Middle, M. Mar	_	me)		:
4 2	s 1 and 2 should f Health and Men item 27 is marke other traumatic	ĭ	19a. Informant's Na				19b. Maili	ng Address (S	1			l Route Numbe		, State, Zip	Code)	
0 E	1 and 2: Health ar em 27 is		David Ca	arpe/Hu	ısband		1002	Cross	Lan	ie, A	bing	don, MI	21009			
/フ/ 04 ore. Mary	oermit. Pages 1 and Department of Health mportant: If item 27 ny injury or other tr ange.		20a. Method of Disp		3 □Removal from		Place of Disponentery, crea	sition (Name of matory or other	of r place)	i i		ate May 11	20c. Location	- City or To	wn, State	
IN I	Pages Iment of tant: If it jury or o		* 4 □ Donation	5 Other (S	pecify)			ake Cre				2004	Beltsv		MD	
A Ball	permit. Pag Department Important: I any injury o		21. Signature of Fu	neral Service 	Licensee	450	2:					eral Al es Driv		ves imore	Approximate	
54382		licai Examiner	disease or condition resulting in death)  Sequentially list condition in any, leading to improve cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, mediate rlying injury	b. — Due to	o (or as a consequence) (or as a consequence) (or as a consequence)	uence of):					- CAV			7-1	
3.2 O. Box 68	the death cert y the attendin	by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	1 Live	utcome of pregna birth 2 ∐Feta gnant at time of d nown	Ideath 3	□Ectopic pregr □ Other (specr						ate of delive	ny Day Ye	ar
JC: C	quires that n signed t	d by P	Part II. Other signif	icant conditi	ons contributing to	b C	ulting in the u	nderlying caus	se given	in Part I.			bacco use cor res 2 □ No			
22 July OC.	The law requi	Completed										24a. Was a autop perfor	med?	death?	psy findings av npletion of cau	allable ise of
Z ig	ysician: Th is certificate director, pag	Be C	25. Was case refer examiner?	red to medica	ı	/			1		of Death	(Check only or				
2	S S	To E	1 ☐ Yes 2 🗷				ER/Outpatie		Other:	4   Nui	-	ne 5 ☐ Resid			1)	
		iuo!	27. Mann f Deat 1 L atural	5 Pendir	'9	of Injury nth, Day Year)	28b. Time of Injury	M 28c.	Work?	t s.2∐h		28d. Describe h	low injury occu	rred		
Z-isi	Attending r death. sctor: After	ficat	2 Accident 3 Suicide	6 Could		e of Injury - At he	ome, farm, st					28f. Location (S	Street and Num	ber or Rura	l Route Numbe	
D S	after Dire	erti	4 🗌 Homicide	detern		ding, etc. (Specif		,,,, -				City or Tow	m, State)			
(2)	To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier (Check only one)	1 Certifyii 2 Medical	ng Physicien: To th Examiner: On the and ma	ne best of my kno basis of examina nner stated.	wledge, deat ition and/or in	h occurred at to execution, in	the time, my opin	date and	d place, a	and due to the d ed at the time, d	cause(s) and n date and place	anner as st	ated. the cause(s)	
	To the within 2 To the comple	Ž	29 Signature and	title of certifie	RO.	De sa	- m	29c. L	icense n	number	/	:	29d. Date sign	ed (Month,	Day, Year)	
	1		10	any	wa	www	55	1	31	77-	5	1	ning	1,2	2004	
_	9		30. Name and addr	P.	EDWA	cos, i	W. 9	Print)	HIT	Fu	STI	AR	1ARG	AND	2101	14
	Sta Regista		31. Date filed (Mon	AY 1 1		Registrar's Signa	J.	Spa	Ms	/			U			

			For State Registrar	State of Ma	aryland	l / Depa <i>Cei</i>	artmer <i>tifica</i>	nt of He te of D	ealth and Death	Mental Hy	/giene Reg. No.	2004	14899
I	Physici /Medic		1. Decedent's Name (First, Middle, L Sidney K.	•	randa:	1.1				2. Date of D Month May		2004 <sup>Year</sup>	3. Time of Death 8:14 P <sub>M</sub>
	Examin		4a. Facility Name (If not institution, g 107 Barnsfield	Ct.			G	aithe	cation of Deat		M	County of Death	
	Funeral Director		5. Social Security Number 6. 508-54-8367  Usual Residence of Decedent	Sex 7. Ag 1 □ M 2 \ F	e (In yrs. las	st birthday) Yrs.	Months		Hours Min.		ay, Year)	9. Birth Cou 943 Ne	olace (State or Foreign ntry) oraska
	aryland show	_	10a. State 10b. County		10c. City,	Town or Lo		0.111	1 1				10d. Inside City Limits
	the Ma	Directo	Maryland Montgo	omery				Galtt	hersbur	g	10g Citiz	en of What Cou	1 ☐ Yes 2 📉 No
	th with	ai Di	107 Barnsfield (	Ct.				208	78			ed Stat	-
036	should be filed within 72 hours atter death with the Maryland of Mental Hygiene. marked other than "netural", or liems 23a or 28a-f show imelic event, it a Madfall Examinar marity modified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💥 I If Yes, Give Year or Dates:			Was Dece f Yes, spe l ☐ Yes		panic Origin? (S , Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		4. Race - Ameri Black, White, Specify: W	
Maryland 21215-0036	within 72 ho	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed)  College (1-4or 5	5+)	life. L	kind of wo DO NOT u	ork done du ise retired)	ring most of wo			d of Business/In	dustry
מ	illed v Hygie other I	Be Co	17. Father's Name (First, Middle, La.	st)		Adılı III.	LSLIZ		Assista 18. Mother's Na	me (First, Middle		urance Sumame)	
ylan	should be and Mental s marked o umetic eve	To B	Orland K		Horn				Lois		0gle		
Mar	ges 1 and 2 should 1 of Health and Men 1f item 27 is marke or other traumetic		19a. Informant's Name/Relationship Kathryn A. Crand		ter		-			ural Route Numb aithersb	-	MD 208	
Baltimore,	Pages 1 a nent of Hei int: If item iry or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spec		cen	ce of Dispo netery, cren sapeak	natory or	other place,		Date 7 ,		ation - City or To	own, State , Maryland
Balti	permit. Page Department of Important: if eny injury or once.		21. Signature of Funeral Service Lic	lumam	M0038	22 E	Name a Rapp	nd Address Funer Sist A	of Facility	Cremati	on Se	rvices Md. 209	910
ľ	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused by one cause on each lin	the death.	Do not ente							Approximate Interval Between Onset and Death 2 Months
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							
	ted nsit	Examiner	Sequentially list conditions, if any, reading to ministrate cause. Enter Underlying Cause (Disease or injury	Due to (or as	в попяедна	nea off:							
68/60,	iticate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	C. Due to (or as	a conseque	nce of):							
	= 0 e	Medicai	IF FEMALE:	U									
SO. BOX	at the death certiti by the attending tached tor use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	eath 3 🗆	Ectopic p Other (s)	regnancy pecify)			23	3d. Date of delive Month	ery Day Year
rds, P	w requires that the been signed by th should be detache		Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the ur	nderlying	cause given	in Part I.				ne cause of death?
Vital Records,	The law ate has b page 2 s	Completed								24a. Was auto perf 1 ☐ Yes	psy ormed?		psy findings available mpletion of cause of
VII.	000	Be	25. Was case referred to medical examiner?	Hospital:				Other		ath (Check only			
on ot	ling After fune	tion; To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da	nt 2□ Ef ry y Year) 2	8b. Time of Injury		28c. Injury a Work?	4   Nursing F	lome 5 X Res 28d. Describe		Other (Specificoccurred	ν)
DIVISION	al or Attendi s after death. Il Director: A id in by the fu	Certification;	3 Suicide 6 Could not determine		ury - At hom c. (Specify)	e, farm, stre	eet, factor	y, office		28f. Location City or To	Street and wn, State)	Number or Rura	l Route Number,
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the Funeral Director Completely filled in the Funeral Director Completely filled in the Funeral Director Completely filled in the Comple	Medical (	29a. Certifying F (Check only one)  1 Certifying F 2 Medicaf Ex	Physician: To the best aminer: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred	at the time	, date and place nion, death occu	, and due to the irred at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
	To the within 2. To the I complet	Σ	29b. Signature and title of certifier	han lo	11.20			c. License r	6105	2	29d. Date	signed (Month,	Day, Year)
	15		30. Name and address of person wh				Print)						~~~
	Sta	tė	Paul M. Thambi, 31. Date filed (Month, Day, Year)		05 Cor ar's Signatui					gton, M	208	895	
	Registr		MAY 1 1 2	004 Sens	va	19	do	all	/				

			State of Maryland / Dep			•	
			_ For	ertificate of Death		. No 2004	16900
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		Robert Breckinridge Chapman, III		May 8,	2004 Year	6:20 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	h
			Greater Baltimore Medical Center	Towson			imore
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	hplace (State or Foreign untry)
	Director		220-01-2620 TAM 2DF 86 Yrs. Usual Residence of Decedent		May 12,	1917 Ma	ryland
	/land		10a. State 10b. County 10c. City, Town or	_ocation			10d. Inside City Limits
:	Mar B-f sh	tor	MD Baltimore Park	ville			1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	untry?
;	23a	ral	8810 Walther Blvd. # 1306	21234		USA	
	er dez	Funeral	11, Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian, e, etc.
36	I', or	by F	1 □ Never Married 2 📉 Married 1 📜 Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🔯 No Specify:		Specify: Wh	ite
ĕ,	illed within 72 hours after death with the Maryland Hygiene Hygiene then "natural", or Items 23a or 28a-f show ant, Ire Medical Examinat mai be notified at	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	6b. Kind of Business/	Industry
215	thin 7 9. "n Media	ple	(Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ang		
2	filed wil Hygien other the	Completed	E	ngineer			/Education
_	m 0 &	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	niden Sumame)	
2	should be filed within 72 hours after death with the Marylan and Mental Hygiene. I Hydiene. I show a marked other then "natural", or Items 23a or 28a-f show umatic event, it e Medical Examinational be notified at	ဥ	Robert Breckinridge Chapman  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Ing Address (Street and Number or Rui		Situate Town State 7	Tin Code)
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or othar treumatic evonce.			O Walther Blvd. #		kville, M	
ē,	f Heal f Heal item? other		20a Method of Disposition 20b. Place of Disp	position (Name of	Date 20	c. Location - City or	
ê .	Page: entol nt: If ry or		1 ☐ Burial 2 M Cremation 3 ☐ Removal from State  1 ☐ Burial 2 M Cremation 3 ☐ Removal from State  1 ☐ Burial 2 M Cremato:  1 ☐ Burial 2 M Cremato:  1 ☐ Burial 2 M Cremato:	ematory or other place) e Washington May rv 200		Laurel,	MD
Baltimore,	mit. partr porta y inju		21. Signature of Funeral Service Licenses	22. Name and Address of Facility			
<u> </u>	88 2 8		Michael J. Flagle	emmon Funeral Home O W. Padonia Road	Timonium	• MD 2109	inc.
			23a. Part Eater the disease, complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition	O			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		<u>_</u>	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	oma			
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
ó	e be executed rsician and e burial-transit		resulting in death) Last  Due to (or as a consequence of):				
	tte be iysicia ne but	cal	d				
89	intifica ing ph as th	Completed by Physician/Med	IF FEMALE:				
Õ.	ath ce ttendi or use	lan/l	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deli	very Day Year
o .	he de the a	yslc	1	Other (specify)			
Division of Vital Records, P.O. Box	that the	/Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
g	jures n sign lld be	d b	Afis, CHF, Aremia, Renal	moficienz	1 ☐ Yes	2 No 3 □ Pro	obably 4 Unknown
Ö	s bee	lete	, , , , , , , , , , , , , , , , , , , ,	/	24a. Was an	24b. Were au	topsy findings available
ၕ	The late that age 2	шо			autopsy performe	d? death? ∫No 1 ☐ Yes	completion of cause of
<u>a</u>	itan: artifica ctor. p	Bec	25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)	<b>\</b>	
<u>~</u>	hysic this ce al dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			ce 6 □Other (Spec	cify)
Z	ling P	lon:	27. Manner of Death  Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b. Time Injury		28d. Describe how	injury occurred	
2	death death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, 9		28f. Location (Stre	et and Number or Ru	ral Route Number.
<u>≥</u>	after after Direct	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	sspite hours ineral y filler		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the cau	se(s) and manner as	stated.
:	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	Som J	Σ	29b. Signature and title bi certifier	29c. License number		. Date signed (Month	n, Day, Year)
7	UX,		m X	V 53603		21101	0 4
	10		30. Name and address of herson who completed cause of death (Item 23a) (Type Dr. Juan Galarraga, M.D. 8800 Walth	<sub>a, Print)</sub> er Blvd. Parkville	MD 2122	4	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	, rw 2123	7	
	Regist		MAY 1 1 2004 Server &	ponts			

			For State Registrar	-	Department of Health and Certificate of Death	Mental Hyg	giene 19g. No. 2004 11.00
	Physici	an	1. Decedent's Name (First, Middle, La			2. Date of Dear Month	Day Year
	/Medic	al	4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of Dea	May	4c. County of Death
	Examili	eı	The Johns Ho	OKINS HOSDITAL	. BALLIMORE CI	ty	NIA
	Funeral		5. Social Security Number 6. 5	ex 7. Age (In yrs. last birt	(thday) If Under 1 Year If Under 24 Hr Months Days Hours Mir		Orean 2 Country)
	Director		Usual Residence of Decedent				MD.
	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examiner must be rediffed at	2	MD . 10b. County	10c. City, Towr	or Location TIMORE		10d. Inside City Limits 1 □ X es 2 □ No
	the M	Director	10e. Street and Number		10f. Zip Code 21234	1	Og. Citizen of What Country?
	ours after death with the Marylan rat', or Itams 23a or 28a-f show Examiner must be rediffed at		2181 pentland	d drive	21234		U.S.A.
	er dea Itams	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	urs aft	by	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ <b>\^</b> No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		SpecifyBLACK
21215-0036	72 hours 'natural', dical Ex	Completed	15. Decedent's E	ducation 16a.	Decedent's Usual Occupation (Give kind of work done during most of w	orking	16b. Kind of Business/Industry
121	d within 72 ho piene. r than "natu the Wedical	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		NIA
מ סר	be filed with tal Hygiene d other tha avant, the I	Be C	17. Father's Name (First, Middle, Last)			ame (First, Middle, M	
ylaı	should be id Mental marked o	To E	DARIUS CANTY			EA SHOR	
Maryland	s 1 and 2 should be filed if Health and Mental Hyg itam 27 is marked othe other traumatic avant,		19a. Informant's Name/Relationship ( RAKYEA SHORT M		Mailing Address (Street and Number or F 2181 pentland D	Rural Route Number	; City or Town, State, Zip Code) LTO . MD . 21234
	of Heal itam itam		20a. Method of Disposition	20b. Place of cemeter	Disposition (Name of	Date	20c. Location - City or Town, State
Baltimore,	nit. Pages bartment of lioriant: If it: injury or o		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)	<i>'</i> )		-14-04	MARYLAND
Balt	permit. Departi		21. Signature of Funeral Service Licer	See A NOOC	22. Name and Address of Facility	lowell	Funeral Home
			23a. Part1. Enter the disease, or com	plications that caused the death. Do n	not enter the mode of dying, such as cardia	ac or respiratory arre	South Mo 2 1207 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	a. Neuroblastom			Interval Between Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or as a consequence of	of):	•	
		Jer	Sequentially list conditions, if any, leading to immediate	b. Firam Negative Due to (or as a consequence of	(Serratia) Sepsi	5	5 days
	acuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c			
(09	ate be executed hysician and he burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequence of	of):		
68760	ifficate g phys as the			, d			
Box	death certifica e attending ph id for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
0	that the death certifica ed by the attending ph detached for use as th	Physiclan/Med	1 Yes 2 No	4□Pregnant at time of death 9□Unknown	5 Other (specify)		Worth Day 1941
<u>ה</u>	requires that the	by Ph	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?
Records	w require been sig should b					1 🗆 Ye	es 2 No 3 Probably 4 Unknown
3ec	e law has b	Completed				24a. Was ar autops	v prior to completion of cause of
Vital	ician: The licertificate ha	e Co	25. Was case referred to medical		26 Place of Do	perform 1 Yes 2	<del></del>
Ţ	ys dis	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 ☐ ER/Out	Othor		nce 6 Other (Specify)
on of	ling Pl	ion:	27. Manner of Death 1 Natural 5 ☐ Pending		ijury Work?	28d. Describe ho	w injury occurred
Division	Attending ir death. actor: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far	M 1 ☐ Yes 2 ☐ No	28f. Location (Str	reet and Number or Rural Route Number,
Ö	s after s after al Dira	Certification;	4  Homicide determined	building, etc. (Specify)		City or Town	i, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Ph	ysicien: To the best of my knowledge, hiner: On the basis of examination and and manner stated.	death occurred at the time, date and plactfor investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	tuse(s) and manner as stated. ate and place, and due to the cause(s)
	To the within To the comple	₩	29b. Signature and title of certifier		29c. License number		9d. Date signed (Month, Day, Year)
)	6		1 King who	a-mo	D 60534	1	May 9,2004
	V)		30. Nam and address of person who Kristen M. Snyder, M.	1 1 100 00	Type, Print)  Baltimore, MD 212	87	
	Sta	100	31. Date filed (Month, Day, Year)	32. Registrar's Signature	7-11-11-12		
	Registr	ar	MAY 1 1	2004	Bosco 8		

			State of Maryland / [					Mental Hy	giene	2001	11000
			Registrar	Cer	tificate	of L	<i>Death</i>	10.5	Reg. No	2004	14902
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	y Year	
4	/Media	al	Virgle Lee Coons  4a. Fecility Name (If not institution, give street and number)		4h City 7	Four or	Location of Oe	05/07		. County of De	2:00 A M
	Examin	er	K HI CHE WAS THE THE					#(I)			
	Euparal		1230 Hillside Road  5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday)	Pasa	1 Year	If Under 24 Hi			nne Ar	irthplace (State or Foreign
	Funeral Director		4 th 4 th 7 th	Yrs.	Months	Days	Hours Mi	n. (Month, Di 08/23	19.79ar	21	Country) WA
	D .		Usuel Residence of Decedent								
	arylar ehow	_	10a. State 10b. County 10c. City, Town								10d. Inside City Limits 1 ☐ Yes 2 💆 No
	8a-f	ecto	MD Anne Arundel Pasad	lena							
	with ti	Ö	10e. Street and Number		10f. Zip				_	izen of What C	Country?
	s 23	by Funeral Director	1230 Hillside Road  11 Marital Status 12. Was Decedent Ever in U.S.	12.1	211		nania Orinina		U.S.	A . 14. Race - Am	noicen Indian
	Item Item	ň	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 12 Yes 2 No 1939	. 13. 1	Yes, speci	ify Cubar	n, Mexican, Pue	(Specify Yes or No arto Rican, etc.)	,-	Black, Wh	
99	urs af	by [	3 Ma Widowed 4 □ Divorced If Yes, Give Year or Dates: 1969	1	Yes 2	No.	Specify:			Specify: Wh	ite
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28s-f ehow he Medical Exarcinar must be textified at	Completed	15. Decedent's Education (Specify only highest grade completed)	Deced	lent's Usual	Occupa	tion	notina		ind of Busines	
2	thin 7	nple	Elementary/Secondary (0·12) College (1·4or 5+)	life. L	OO NOT use	e retired)	uring most of w	Orking			
7	filed wi Hygien Sther th	Con	12	Mar	nager	-			DC		
and E	be fill tal H d off	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle		Sumame)	
<u>=</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be indiffied at	2	Loran Simeon Coons  19a. Informant's Name/Relationship (Type, Print)  19b	Mailia	- A -l -l	(Ctennt o		May Bal		Town State	Tie Code)
Ma	d 2 sl th and 7 is r traur										
á,	1 and Health tem 27		Sharon Freeburger/Daughter 1 20a. Method of Disposition   20b. Place of	Dispos	sition (Nam	e of		Date		ocation - City o	
lo L	ages ant of it: If it		1 🗆 Burial 2 📕 Cremation 3 🗀 Hemoval from State	-	natory or oth		1	/07/04	D ~ 1 L		MD
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2' any injury or othar is once.	1	21. Signature of Funeral Service Licensee								1 Home, PA
ä	Dep Per		Graf Gor					,Pasad			
Ь			23a. Part1. Enter the disease, or complications that caused the death. Dor shock, or heaft failure. List only one cause on each line.								Approximate Interval Between
	Physician		Immediate Cause Final disease or condition	(	7	110	Meland	~ Di	Co a	0	Onset and Oeath
des	/Medical		resulting in death)  Due to (or as e consequence	of):		VIV	000	02.1	200		(1)
	Examiner		Sequentially list conditions b.								
	po is	Examiner	Securities to differ s if any, leading to immediate cause. Enter Underlying	of):							
1	and I-trans	xam	Cause (Disease or injury that initiated events c	of).							
8760,\	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al E	540 10 (01 45 45 50 50 50 50 50 50 50 50 50 50 50 50 50	01/.			•				
687	hcate phys s the	Physiclan/Medical	d								
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							23d. Date of de	elivery
m	<ul> <li>requires that the death certific</li> <li>been signed by the attending p</li> <li>should be detached for use as</li> </ul>	icla	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death		Ectopic pre Other (spe					Month	Day Year
0.0	t the by the	hys	9 Unknown								
	gned ged oe de	by P	Part II. Other significant conditions contributing to death but not resulting in	n the un	iderlying ca	use give	n in Part I.	23e. Did t	obacco u	ise contribute	to the cause of death?
ord	en si	peq						122	Yes 2[	□ No 3 □ F	robably 4 □Unknown
Records,	has be	ple						24a. Was		24b. Were a	utopsy findings available completion of cause of
	The sate h page	Completed						1 Tes	rmed?	death?	$\Delta t$
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			0.1		eath (Check only o	one)		
5	Physi this c	T <sub>0</sub>	1   Yes 2   No Hospital: 1   Inpatient 2   ER/Ou				4   Nursing			6 □Other (Spe	ecify)
Division of	Attending Physician: or death. ector: After this certification in the funeral director. It	Hon	1 Natural 5 Pending (Month, Day Year) II	Time of njury	M 28	C. Injury Work	at ? es 2 □ No	28d. Oe ribe	now injur	y occurred	
2	death ctor: / y the f	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	ım. stre			03 20.10	28f. Location (	Street and	d Number or F	Rural Route Number,
<u> </u>	after Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		,			City or To	wn, State,	)	
	Hospital or Attending 124 hours after death. Funeral Director: After tely filled in by the funer	edical C	29a. Certifier (Check only Medicel Examiner: On the best of my knowledge Medicel Examiner: On the basis of examination an	e, death	occurred a	t the time	e, date and place	be, and due to the	cause(s)	and manner a	s stated.
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medi	one) and manner stated.			License					
)	To To	-	29b. Signature and title of certifier		Z9C.	/ 2	1	7	M	e signed (Mon	III, Day, rear)
	to		30. Name and address of persons in completed cause of death (Item 23a) (	/Type '	2 cint\	ソノ	177	/	110	1-1	,2007
	21		Wisten and association of the state of the s	7 C	120	Sal	Lat 1	art. C	-lan	Burn	M17106
1	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature		, - 1	2.			1111	1	7 11 0 11
	Registr	ar	MAY 1 1 2004 Marche &	1	Good	2	·				
				-	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend Item 1 per Dr, G831, 05/11/04dhb Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) J. Casev Anna Day Month **Physician** 1:20 A M ANNA CASEY MAY 09 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GENESIS RANDALLSTOWN RANDALLSTOWN

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. BALTIMORE COUNTY Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 21 F 94 212-74-7549 Director May 08 1910 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28e-f show Littleton 1 ☐ Yes 2 ☑ No Colorado Arapahoe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir then "naturel", or items 23s or ā 80120 U.S.A. 5907 South Gallup Street Apt. 302 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 2 3 N Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hrabak Josefa Humlova Frank 27 is marked traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5907 South Gallup Street, Littleton Co. 80122 Kenneth Casey Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it eny injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 Dother (Specify) 05/12/04 Baltimore, Md. Cedar Hill Cemetery 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature of Funera Service Licenses 237 F. Patapsce Ave. Baltimere, Md. inck, or heart failure. List only one suse on ach line. Approximate Interval Between Onset and Death mmediate Cause (Final 10 O YEARS Physician alsease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnapt 3 Ectopic pregnancy in the past 12 month Month Day Year 4☐Pregnant at time of death
9☐Unknown 5 Other (specify) 2 No 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ebro Vascular accident 2-No 3 Probably 4 □Unknown 1 🗌 Yes Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 s autopsy certificate 2/1 No 1 Yes 22 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2. No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of centifier D0020964 5/10/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown MD 21133 31. Date filed (Month, Day, Year) MAY 1 1 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Maryla		artment of H			giene Reg. No. 2001	+ 14904
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Edna Barnes Vi	nson Coen				Month May	Day Year 7 2004	13:10 M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	
		٠,	Harford Memorial				le Grace		Harford	
	Funeral		5. Social Security Number 6. S	□M 2√2F	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	v. Year) C	thplace (State or Foreign ountry)
	Director		243-30-2775 Usuel Residence of Decedent	A	80 '''			August	10,1923 Noi	cth Carolina
	land •••		10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
	Mary I sh	tor	Maryland Harfo	ord A	berdeer	ı				1 ☐ Yes 2 ☐ No
	r 28g	Directo	10e. Street and Number	10		10f. Zip Code			10g. Citizen of What C	ountry?
	th wit		2120 Park Beach	Drive		21001			USA	
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi	ispanic Origin? (Sp.n., Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whi	
9	or It		1 Never Married 2X Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 🖾 No	Specify:		Specify:	
215-0036	be tiled within 72 hours after death with the Maryland tal Hyglene death with the Maryland of other than "natural", or items 23a or 28a-f show event, In. Medical Examinational to indiffe Jai	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1Co Door	dante Union Occupa				nite
5	"naf	Completed	(Specify only highest gra	de completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of won	king	16b. Kind of Business	vindustry
212	with iene. than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	,		Own Home	
Ö	tiled I Hyg other	Be C	17. Father's Name (First, Middle, Last)		1101		18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
<u>a</u>	should be and Mental   e marked o	To B	Charlie Edmond Vi	nson			Ivie (ur	ık) Greei	n	
Maryland 21	2 should be and Mental le marked (	_	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town, State,	Zip Code)
	ss t and 2 of Health a litem 27 le r other trai		Lester G. Coen -	Husband	2120	Park Beac	h Dr A	berdeen,	, Maryland	21001
ore O	ges 1 t of He if iten or oth		20a. Method of Disposition  1 38urial 2 Cremation 3		Place of Dispo cemetery, crei	sition (Name of matory or other place	θ)	Date	20c. Location - City or	Town, State
Ĕ	Pages ment of ent: If it ury or o		'4 □Donation 5 □ Other (Specify	Wh:	ite Oak	Church C	em. May, 1	2,2004	layton, Nor	th Carolina
Baltimore,	permit. Page Department ( Importent: If eny injury or once.		21 Strature of Funeral Service Licer	(). 1	22 M	Name and Address Fu	s of Facility neral Ho	me		
	<b>₹</b> □ <b>= □</b>	) D	23a. Part1. Enter the disease, or com shock, or hear failure. List only	as Kenningt	1	317 Cokes	bury Rd.	, Abingd	lon, Maryla	nd 21009
				plications that caused the de one cause on each line.	and the same of		g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Seps	7.5				4 days
	/Medical Examiner		Tosbing in doding	Due to (or as a conse	equence of):					,
		Į.	Sequentially list conditions,	b. Due to (or as a conse	equence of):					
	nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.		4-2					
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
8/60	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	(	d.						
9	tificat ng phy as th	ledi								
ХOЯ	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date of de	
D	ed fo	sicia	in the past 12 months? 1 □ Yes 2 No	4□Pregnant at time of 9□Unknown		Other (specify)			Month	Day Year
J.	res that the de signed by the a be detached f	Physician/Me	9 Unknown				a la Bankl	OD: Dida:	hann our restribute to	- Ab
Ś	res th	þ	Part II. Other significant conditions of	Acutal Pre	esulting in the u	nderlying cause give	on in Part 1.		bacco use contribute to es 2⊠No 3□Pt	robably 4 Unknown
Vital Records,	w requir been si should I	Completed	-	Chronec ly	- 11	1 1	4 / 20			
ş Ç	The law cate has t page 2 s	npl			Sulvo	cyne L	encem	24a. Was a autops perfor	an 24b. Were as sy prior to med? death?	topsy findings available completion of cause of
				Proumenia	•	<u>-</u>			2No 1□Yes	2 □ No
<b>5</b>	yeician: iis certific director,	o Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deal		*	
ō	Phys rthis raldi	-	1 ☐ Yes 25 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	☐ ER/Outpatier 28b. Time of	IL DU DON	4 Liversing in		ence 6 □Other (Spe ow injury occurred	cify)
0	ding P th. : Atter t tunera	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	Work	(? (es 2 □ No			
DIVISION OF	Attence r death	ifica	3 ☐ Suicide 6 ☐ Could not be	200. Flace of injuly - At	home, farm, str	eet, factory, office		28f. Location (S	treet and Number or Ri	ural Route Number,
á	al or At s after d of Direct of in by	Certification;	4  Homicide	building, etc. (Spec	city)			City or Town	n, State)	
	To the Hospital or Attending Physician: white 24 hours after deals at the father. To the Funerel Director: Atter this certifica completely tilled in by the tuneral director.		29a. Certifier Certifying Ph	ysician: To the best of my ki	nowledge, death	occurred at the tim	e, date and place,	and due to the c	ause(s) and manner as	stated.
	in 24 in 24 ine Fi	Medical	one)	and manner stated.	Tation and/or in	vestigation, in my op	omion, death occur	ned at the time, d	ate and place, and due	to the cause(s)
	With To I	2	29b. Signature and title of certifier	RZA A-B.	416 1	29c. License			29d. Date signed (Mont	
	$\cap$	,	1 122				43115		2-8-09	
	1,8		30. Name and address of person who 615, S- Let	completed cause of death (Ite	em 23a) (Type,	Print) Mir	za A. Ba	ig, MA	5-8-04	25
	1		31. Date filed (Month, Day, Year)	32. Registrar's Sign		or all	0),,000	1 2000	2	0
	Sta Registr		MAY 1 1 2004	oz. negistrar s Sigi	natur <del>d</del>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per Dr., 331,05/11/04/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 7:039 M George Allen Counts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square 5. Social Security Number HUSPI tal Boseda le If Under 1 Year | If Under 24 Hrs. 6 Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Hours Yrs. Director 240-05-1306 86 07/10/1917 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at MD 1 TYes 2X No Director Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 5324 Forge Road 21162 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi 2 James Marshall Counts Elizabeth C. Rasnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tree 5324 Forge Road - White Marsh, MD Goldia N. Counts (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 X Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 05/05/2004 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses (GD 11750 Belair Road - Kingsville, MD 21087 aga 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Benal Heute tailure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Biventricular HeartFailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Ischemic Cardiomyopathy Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð 1 Yes 2 4No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 ANO 2□ No Division of Vital 1 Yes 1 Yes Hospitel or Attending Physicien: Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Denpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 0 2 1 No 1 Yes 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the whithin to the comple 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

MAY 1 1 2004

30. Name and address of person

ICINO

Mikityanskaya 4000 tran 32. Registrar's Signature 2004 Betwee & Spark

who completed cause of death (Item 23a) (Type, Print)

			State of Maryla State Pegistrar	and / Depa <i>Cei</i>	artment of I	lealth and Death		Reg. No. CU	04 149	06
	Physici		1. Decedent's Name (First, Middle, Last)  Bertha May Danfo.	rth			2. Date of De Month MAY	5, Day 2004	3. Time of Di 11:30t	
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Frederick Villa Nursing Home		Cator	or Location of Deal	ath	4c. County Bal	of Death timore	
	Funeral Director		4 Class of Street	rs. last birthday) 82 Yrs.	If Under 1 Year Months Days			th y, Year) 3, 1922	9. Birthplace (State or F Country) Virginia	Foreign
	the Maryland r 28e-f show	rector		city, Town or Lo				10g. Citizen of V	10d. Inside City 1 Yes 2 What Country?	
92	parmit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28e-f show appring or other traumatic event, I'm Medical Examinat must be multipled at once.	/ Funeral Director	1611 Parkman Avenue  11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes, Give  1 □ Yes, Give		21230 Was Decedent of If Yes, specify Cub		(Specify Yes or No erto Rican, etc.)	USA  14. Race Blace Specify	e - American Indian, ck, White, etc.	
21215-0036	within 72 hours ane. then "natural", the Medical Exe	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+)	16a. Dece	lent's Usual Occu kind of work done DO NOT use retire	pation	rorking		usiness/Industry	
Maryland 2	ould be filad v Mental Hygie arkad other t atic evant, II	To Be Co	17. Father's Name <i>(First, Middle, Last)</i> William Edwin Chiveral			Melody	ame (First, Middle, y Jones	Maiden Sumam	(e)	
	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relationship (Type, Print) Kathleen Spittel/Daughter	2919	Georgia	Avenue	-	orpe, M	D 21227	
Baltimore,	Pages 1 ment of H ant: If itar ury or oth			etro Cre	sition (Name of natory or other pla ematory I	$nc. \mid 5-1$		Baltimo	city or Town, State	
Balt	parmit. Dapart Import eny inj		21. Signature on Funeral Service Licensee  Data M. AcDonald  23a. Part1. Enter the disease, or complications that caused the d				Home, P.A ad Cat		e, MD 21228	8
68760,	death certificate be executed  was a strenging physician and id for use as the burial-transit	Ical Examiner	shock, or heart failure. List only one cause on each line.	sequence of):	Breast	-			Interval Betwe Onset and De	en eath
P.O. Box 68	ath certific attending p for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of precent in the past 12 ☐ Pregnant at t	etal death 3	Ectopic pregnanc	Ży		23d. Dat Mor	e of delivery nth Day Yea	ar
	w requires that the de been signad by the should ba detached		Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.			ribute to the cause of dea	
al Records,	The lay ate has page 2	Completed					1 ☐ Yes	osy ormed? d 2X No 1	Nere autopsy findings avanterior to completion of caudeath?  Yes 2 No	ailable ise of
f Vit	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	2 ☐ ER/Outpatien	t 3□ DOA Ot	D. S. S. S. S. S. S. S. S. S. S. S. S. S.	eath <i>(Check only c</i> Home 5 Resid		er (Specify)	
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Place of Injury A		M 1	Yes 2□No		now injury occurr	ed er or Rural Route Numbe	er.
Div	spital or A ours after herel Dire filled in by	al Certi	4 ☐ Homicide building, etc. (Sp  29a. Certifier 1 Certifying Physician: To the best of my	ecify)			City or Tou	vn, State)		
	o the Hos ithin 24 h o the Fur ompletely	Medical	(Check only one)  2 Medical Examiner: On the basis of exam and manner stated.  29b. Signature and title of certifier	ination and/or in	estigation, in my	opinion, death oc se number	curred at the time,	date and place, a	and due to the cause(s)  1 (Month, Day, Year)	
	15		Waymund MWw  30. Name and address of person who completed cause of death (	Itam 22a) (Tuno	D4	7683		5/6/0	4	
_	1		Raymond Miller 25 Main Stre	4 Sinte		ishestown	MI			
	Sta Registi		31. Data-Hidd (Month, Day, Year) 32. Registrar's Si	gnature	oals					

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004

								Certif	ficate	of I	Death			Reg. N	io.			
			1. Decedent's Name (First,	Middle, L.	ast)								2. Date of D Month			.,	3. Tim	e of Death
	Physicia	_	MARIO	0	ELGIC	11)106							MAV	4	ay 2	004	2:	17 Pm
1	/Medica Examine	-	4a Facility Name (If not insi							4	b. City, To	wn, or Lo	cation of Dea	th 4		of Death		
A STATE OF	Examine		FOREST	14A	VENIN	14R511	VG	HOR	ME	1	PATE	ONS	VILL	4	BA	LTII	nok	E
	Funeral Director		5. Social Security Number 038-20-2138		Sex 1M 2□ F	7. Age (In yr.		hday) I	f Under 1	Year	If Under 2 Hours		8. Date of B (Month D 5/6/19	inth				ate or Foreign
	Director	ŀ	Usuel Residence of Decede	nt									3/0/23					
	tand	ı	10a. State 10b. C			10c. C	City, Town	or Locati	ion			_				1	0d. Insid	e City Limits
	in the Marylan x 28a-f ahow notified	octor		ne Ar	undel		G1en	Burr										Yes 21 No
	23a or 2	Funeral Director	10e. Street and Number 103 Juniper	Cour	ct				10f. Zip Ci 210						Sitizen of SA	What Cour	try?	
020	Exam	2	11. Marital Status  1 □ Never Married 2 □  3 ☒ Widowed 4 □ Div		Armed F	2 ☐ No live	U,S.		Decedences, specify Yes 20		ispanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-		e - Americ ck, White, v: Wh		n,
Q M	natural;	9			ducation		16a.	Decedent	's Usual C	Occupa	ation	ad consider		16b.	Kind of B	usiness/Ind	lustry	
	within 7 ene. than "n	Completed	Elementary/Secondary (0	-	rede completed College	(1-4or 5+)	Me	life. DO	NOT use	retired	iuring most ) Lcian	or works	ng	He	alth	care		
and 2	should be filed withing the Mental Hygiene.  marked other than matic evant, the Mental matic evant.	lo Be	17. Father's Name (First, Mi Benjamin De										(First, Middle		n Surn <b>a</b> n	7 <b>9</b> )		
Σ	2000		19a. Informant's Name/Rela			ghter		_					are,Ste	_				63
Baltimore,	permit. Peges 1 end Depertmant of Heelth Important: if Itam 27 any injury or other tr once.	-	20a. Method of Disposition 1 I Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth	tion 3 [	☐Removal from	20b.	cemeter	v, cremato	on (Name ory or othe	r plac		5,	Date / 12 / 200	20c. I	Location -	City or To	wn, State	e ID
Baltir	permit. Pege Depertment of Importent: if any injury on pnce.		21. Signature of neral Se			M0136	<b>J</b> = ==	22. Na	ame and A	Addres	s of Facility	Sin	gleton en Burn	Fur	neral	. Home		
		4	VILM	LU	uas										TID .	21001	Approxi	
	Physician /Medical Examiner	a.	23a. Part1. Enter the diseas shock, or heart failure.  Immediate Cause (Final disease or condition resulting in death)	List Oilly	Α.,	TASTA.	TIC		Leir			_	VEEK				Onset a	Between nd Death
	ding search	/wedic	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b			onsequen										
00	d for	<u> </u>	Part II. Other elemificant co.	aditions .	oosteibuting to s	looth but not so	aultina in	the under	duina agus	20.00	e in Deat I		22h Did	tohooo	0.1100.000	2015	the ear	as of death?
л О	d by the detached	Z Z	Part II. Other significant co	iditions (	contributing to c	ea(ii bu( no( re	sulung in	(ne unuer	nying caus	se give	m in Parti.				2 □ No	3 □ Prob		se of death? 4 ☑ Unknowr
Records,	as been s 2 should	Completed by											24a. Was	an auto ormed?	opsy	ava	ilable pr	esy findings ior to of cause
r ;	ate h page	5											*D	Yas I	BENO	1 🗆	] Yes	2 No
9	certificate		25. Was case referred to me	dical							26. Place	of Death	(Check only	one)		1		
	el di	2		ending	28a. Date (Mor	Inpatient 2 [ of Injury oth, Dey Year)	28b. Ti	me of jury	3 DOA 28c.	Othe Injury Work	4 Nur	2	ne 5 Resi				)	
	5 등 등 등	Sei III Cal	3 Suicide 6 □ C	vestigatio ould not b etermined	28e. Place	e of Injury - At I ling, etc. <i>(Sp</i> ec					765 Z [] N	_	8f. Location ( City or To			er or Rura	Route I	Number,
1	within 24 hours To the Funeral completely filled		29a. Certifier 1 Cer (Check only 2 Med	tifying Pl lical Exa	nysician: To the miner: On the b and mar	e best of my kn easis of examin ener stated.	owledge, ation and	death occion	curred at t igation, in	he tim	e, date and inion, death	place, a occurre	ind due to the ad at the time,	cause(s	s) and ma nd place,	inner as stand due to	ated. the cau:	se(s)
4	ompl		29b. Signature and title of ce	rtifier					29c. L	icense	number			29d. D:	ate signe	d (Month, L	Day, Yes	r)
ď	-3+8 T		Jasu	eu	4	allia	an			<u>)</u>	3 81-0	1		57	90/0	14		
	3		30. Name and address of pe	rson who	completed cau	se of death (Ite	m 23a) (1 72 2		PAR	k	118	197	trs F	FVE	, 1.	AU	3 M	1) 2/26
	State		31. Dete filed (Month, Day, )	'ear)	32. F	Registrar's Sign	ature	1.	1									

DHMH 16 Rev 6/95

				partment of Health and Mental ertificate of Death	Hygiene Reg. No. 2004 14908
	Physici /Medic		Decedent's Name (First, Middle, Last)     Thomas Daehnke	2. Date Mont 0.5	I I I M
A.	Examir		4a. Fecility Name (If not institution, give street and number) 1924 Breitwert Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Deeth N/A
	Funeral Director		5. Social Security Number  216-62-6018  6. Sex 1 M 2 F  7. Age (In yrs. last birthday 49 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date   Months   Days   Hours   Min.   Jul.	of Birth 9. Birthplece (State or Foreign Country) 17, 1954 Maryland
	Maryland -f ehow	tor	Usuel Residence of Decedent     10a. State   10b. County   10c. City, Town or I	ocation Baltimore	10d. Inside City Limits
	with the or 28a	Direc	10e. Street and Number 1924 Breitwert Avenue	10f. Zip Code	10g. Citizen of What Country?
36	be filed within 72 hours after death with the Maryland ital Hygiene. dother then "naturel", or Items 23e or 28e-f show event, the Medical Examinat must be notified at	by Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes ②□ No Specify:	or No- c:)  14. Rece - American Indian, Bleck, White, etc.  Specify: White
21215-0036	- 44	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) itorial Services	16b. Kind of Business/Industry Uniform Supply
Maryland 2	should be filed withir nd Mental Hygiene. marked other then imatic event, the Mark	To Be Co	17. Father's Name (First, Middle, Last) William James Daehnke	18. Mother's Name (First, M Rose Marie	liddle. Maiden Sumame) Lobell
	1 and 2: Health a tem 27 io		Rose Marie Daehnke Mother 1924  20a. Method of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place	amatory or other place)	
Baltimore,	permit. Pages Department of I Importent: If it eny in ury or o	(	Donation 5 □ Other (Specify)  Meadowric  Memoria  Meadowric  Memoria  Memoria	Ige 1 Park 5-8-2004 12 Name and Address of Amilbrose Fun 12719 Hammonds Ferry Rd.	eral Home of Lansdowne
)	Physician		23a. Pert1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		
8760,	/Medical Examiner  physician and the burial-transit	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	lung cancer	yrs
O. Box 6	at the death certifical by the attending phy tached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
ecords, P.	law requires that the as deen signed by the 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the		Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
I	The ate page	Completed			Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
sion of Vital	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1		P sidence 6 □Other (Specify)  ribe how injury occurred
DIVISION	2 t 2 c	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	City o	ion (Street and Number or Rural Route Number, r Town, State)
	To the Hospitel within 24 hours a To the Funerel C completely filled	Medical	29a. Certifier  (Check only one)  Dertifying Physicien: To the best of my knowledge, dea (Check only one)  Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurred at the t	ime, date and place, and due to the cause(s)
	or to con	-	29b. Signature and title of certifier  MID  MID  MID	29c. License number  D/8587	29d. Date signed (Month, Day, Year) MAY 5 2004
	5		30. Name and address of person who completed cause of death (Item 23a) (Type  A V TO RM (F. 9)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	aton Ave Ba	MAY 5 2004 Himore MD 21229
	Sta Registr		MAY 1 1 2004 Server & A	souls !	

/Medi	ian cal	Decedent's Name (First, Middle, L		ret Donoh	ıe				2. Date of De Month	May <sup>Day</sup> May <b>4</b> , 2	2004 Yea	3. Time of Dea 2:45 p.
Examir		4a. Facility Name (If not institution, ga	ive street and number 2920 Triadelp		4b. City,	Town, or	Locetion of I		ott City	4c. C	ounty of De	eath Howard
uneral irector		222-14-0224	Sex 7.	Age (In yrs. last birtho	Months	1 Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Bir (Month, Da March 1			Birthplace (State or Fo Country)  Delaware
Mo H		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City Li
a-f sh	ctor	Maryland H	Howard			El	licott City	′				1 □ Yes 2
3a or 28	Funeral Director	10e. Street and Number 12920 Triadelphia Rd			10f. Zip	Code	2104	2		10g. Citize	on of What	Country? J.S.A.
ems 2:	nera	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	3. Was Deced	dent of Hi	spanic Origin	? (Spe	cify Yes or No Rican, etc.)	14		nerican Indian,
of other than "natural", or liems 23s or 28s-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Date	XNo	_	2 No	Specify:	uerto	nican, etc./		Black, WI pecify:	White
"natu	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	16a. Do	cedent's Usua ive kind of wo e. DO NOT us	al Occupa	ation during most o	f workii	ng	16b. Kind	of Busines	ss/Industry
Than the M	omp	Elementary/Secondary (0-12)	College (1-4d	or 5+)	5	itra-	tive F	ksi	stant	1	050	0
marked other than imatic event, the M	BeC	17. Father's Name (First, Middle, Las	st)			71100	18. Mother's	Name	(First, Middle,	Maiden Su	umame)	<u> </u>
narked o	J.	John 4		OHN KEYES			IMa	50	aret		nor	)
2 2		19a. Informant's Name/Relationship  Mrs. Peggy Keyes							Route Number tt City, Ma			, Zip Code)
		20a. Method of Disposition		20b. Place of Di		ne of	1		ate			or Town, State
y or		1 ■ Burial 2 □ Cremation 3   1 □ Donation 5 □ Other (Spec		to Cathodo	al Cen	otes	5	-77.	D4	Wilm	inator	N.
Important: any injury o once.		21. Signature of Funeral Servi Lio	Parl 1	MO1293	22. Name an	d Addres	s o Facility	381	H ad	2014	more	iFike
= # C4	Н	23a Part 1 Extensible disease of con-	TUCKU	ed the death. Do not	Slack	hur	<i>vralf</i>	DW	الماع ما	cott	City	MO OLD- Approximate
		23a. Part1. Extenthe disease, or conshock, or heart failure. List onto			enter the mod	o or dying	, such as ca	idiac o	respiratory ar	1621,		Interval Betwee
sician edical		disease or condition resulting in death)		TATIC SIGNA	eis Co	lon	lance					Imall
miner		Sequentially list conditions,	b									
ısıt	Examiner	dany leading to him addits cause. Enter Underlying Cause (Disease or injury	Due to (or )	ar a consequence of):								13
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al-tra	Liúi I	that initiated events resulting in death) Last	Due to (or a	as a consequence of):								
ysician and se burial-tra		that initiated events	Due to (or a	as a consequence of):								
ing physician and e as the burial-transit		that initiated events resulting in death) Last	d					-				
attending p for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	ne of pregnancy	3 ☐ Ectopic pr			-		23d	d. Date of d	
attending p for use as		resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d	ne of pregnancy 2  Fetal death at time of death	3 ⊟Ectopic pro					23d		
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tter this certificate has been signed by the attending p neral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown contributing to death	ne of pregnancy 2   Fetal death at time of death  but not resulting in th	5 Other (spins a underlying calling the spins a underlying the underlying the spins a underlying the underlying th	ause give	26. Place of F: 4□ Nursii	ng Hom	24a. Was autop perfor 1 Yes	an 2 No ne)	Month  contribute  of 3 f  f  24b. Were a prior to death? 1 f  Other (Sp	Day Year to the cause of death Probably 4 □Unkn autopsy findings avail p completion of cause us 2 □ No
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<b>runeral Director:</b> After this certificate has been signed by the attending <b>r</b> sky filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	d. 23c. If yes, outcon 1	ne of pregnancy 2 Fetal death at time of death in but not resulting in th titient 2 ER/Outpa njury 28b. Tim Injury At home, farm, etc. (Specify)	a underlying ca	ause give  A Othe  8c. Injury Work  1  Y	26. Place of  4 \( \text{Nursin} \) at ? (es 2 \( \text{No} \)	2 lace a	24a. Was autop perfoil 1  Yes  (Check only one 5 Resident Section (Section	obacco use  (es 2 ]  an sy med?  an (sy) med?  con (ne)  lence 6 [  cow injury or  cov injury or	Month  contribute  46 3 6 7  24b. Were a prior to death?  1 7 Ye  Other (Sp	Day Year  to the cause of death  Probably 4 □Unknot  autopsy findings availa  completion of cause  as 2 □ No  Rural Route Number,
<b>runeral Director:</b> After this certificate has been signed by the attending <b>r</b> sky filled in by the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5  Pending investigations 2  Accident 3 Suicide 6 Could not 4 Homicide	23c. If yes, outcon 1	ne of pregnancy 2 Fetal death at time of death in but not resulting in th titient 2 ER/Outpa njury 28b. Tim Injury At home, farm, etc. (Specify)	ient 3 DO o of y M street, factory authoccurred a investigation,	ause give  A Othe  8c. Injury Work  1  Y	26. Place of  4 Nursin at ?  6s 2 No e, date and p	2 lace a	24a. Was autop performed to the control of the cont	obacco use  Yes 2  In an 2  In an 2  In an 2  In an 2  In an 3  In an 4  In	Month  contribute  46 3   f  24b. Were a prior to death? 1   Ye  Other (Sp  courred	Day Year  to the cause of death  Probably 4 Unknown  autopsy findings available completion of cause  as 2 No  Pecify)  Rural Route Number,  as stated.  te to the cause(s)
Director: After this certificate has been signed by the attending r in by the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 25 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigated investigated investigated 4 Homicide  29a. Certifier (Check only one)	d. 23c. If yes, outcon 1	ne of pregnancy 2   Fetal death at time of death  at time of death	ient 3 DO of y M street, factory ath occurred a investigation,	ause give  A Othe  Bc. Injury Work  1  Y  , office  at the timm in my op	26. Place of  4 Nursin at ? es 2 No e, date and p inion, death o	2 lace, a occurre	24a. Was autop performed to the control of the cont	obacco use  Yes 2 1 2 1 2 2 1 No 2 2 2 1 No 2 2 2 1 No 2 2 2 1 No 2 2 2 1 No 2 2 2 1 No 2 2 2 1 No 2 2 2 1 No 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 1 No 2 2 2 2 2 1 No 2 2 2 2 2 1 No 2 2 2 2 2 2 No 2 2 2 2 2 2 2 2 2 2 2	Month  contribute  46 3 45. Were a prior to death?  1 Ye  Other (Sp courred	Day Year  to the cause of death  Probably 4 □Unkn  autopsy findings avail  completion of cause  as 2 □ No  Pecify)  Rural Route Number,

DHMH 17 Rev 1/2001

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Patient

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** В. Elliott Martha 4c. County of Deeth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NA Baltimore Stella Maris-Mercy If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9-9-52 Birthplece (State or Foreign Country)
 51 **Funeral** Days Hours 1 M 2 F 245-92-1260 Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturei", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ¥ Yes 2 No Baltimore Md. Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1343 Meridene Dr. 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 ☐ Yes 🎇 No Specify: Black þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic 900s. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Bookkeeper Super Fresh 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Allen Mabery Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilbert J. Elliott, Jr. Husband 1343 Meridene Dr., Baltiwere, Md. sposition (Name of Date 20c. Location-20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Arbutus Mem. Pk. Arbutus, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 M 1101 E. North Ave. March F.H. East Warne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** > CCN> /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner and Il-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Division of Vital Records, P.O. Box 68760, signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à icate has been sign. page 2 should b 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Priner (Specify) 1 Yes 2 No Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: I in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled is Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 040854 5/10 2004 30. Name and address of person who\_completed cause of death (Item 23a) (Type, Print) Bultimore 5+ Paul 11 Lisebers 301 2121 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

			For State		epartment of Health and	Mental Hy		010
			Registrar		Certificate of Death	10.500 45	Reg. No 2004	912
	Physici	an	1. Decedent's Name (First, Middle, L	CALGODA		2. Date of Do	Day Year	
,	/Medic		4a. Facility Name (If not institution, gr	L CN G (W)	4b. City, Town, or Location of Deal	May 3	, 2004 11:0	)7 P <sup>M</sup>
4	Examin	er	John Hopkins H	•			land of Balan	
	Funeral		<ol><li>Social Security Number 6.</li></ol>	Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		rth 9. Birthplace (State ay, Year)	or Foreign
	Director		120-67-5715	1 M 2 XF 47 Y	rs. Months Days Hours Min.	013	156 Georgi	2
	and **		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town	or Location		10d. Inside (	City Limits
	Maryl f sho	ior	M	Ral.	tiana			s 2 No
	r 28a	Irec	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
	th witl 23e o	ai D	608 E. 364	1 Street	21218		USA	
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	specify Yes or Note to Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.	
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Place	
5-0036	72 hours after death with the Maryland natural', or items 23e or 28e-f show ileal Esaniner must be natilied at	ed k	15. Decedent's 8	ducation 16a. 0	Decedent's Usual Occupation		16b. Kind of Business/Industry	
215	within 72 ene. then "na	pie	(Specify only highest g. Elementary/Secondary (0-12)	rade completed) (  College (1-4or 5+)	Give kind of work done during most of wo life.  DO NOT us <del>e re</del> tired)	rking	1600:41	
21	filed wit Hygiene ther the	Completed	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4 years	LHN		HOSPITAL	
nd	tral Hydr	To Be	7 Father's Name (First, Middle, Las		18. Mother's Na	me (First, Middle	, Maiden Surname)	
Maryland	2 should be fited within and Mental Hygiene. Is marked other then aumatic event, Ite M.	2	19a, Info ant's Name/Relationship	YYI AM	Mailing Address (Street and Number or R		or City or Town State 7in Code)	
Z	th an		Camico Wil	liano (Doudter) 6	08 F · 3/44 9	tret	D-140-MD 2171	18
ē,	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiens.  If item 27 is marked other then.  or other traumatic event, the Medical Examination and be notified at		20a. Method of Disposition	— namatani	Disposition (Name of crematory or other place)	Date	20c. Location - City or Town, State	
altimore,	Page nent o int: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State ( )	wood (emetery 51	10/04	Paltinge M	IN
alti	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Lice	nsee	2/Name and Addr. ss (3 a mit)	ine Fr	werel Service	es
<u>B</u>	89589		1 augu C	Lune	405 york	Road	Balto MD 212	212
			shock, or heart failure. List only	nplications that caused the death. Do no y one cause on each line.	ot enter the mode of dying, such as cardia	c or respiratory a	rest, Approxima Interval Be Onset and	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Multiple infries			011001 4110	, Douth
	/Medical Examiner		Tooling in south,	Due to (or as a consequence of	):			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of	):			
	d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C				
0,	e exer	Exa	resulting in death) Last	Due to (or as a consequence of	):			
68760,	ficate be executed physician and s the burial-transit	edicai	•	d				· · · · · · · · · · · · · · · · · · ·
_	= D 6		IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		Month Day	Year
0	that the de ned by the s detached f	hysi	1  Yes 2  No 9-⊠Unknown	9□ Unknown				
S, D	es that igned be be det	by P	Part II. Other significant conditions	contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did	tobacco use contribute to the cause of	death?
ord	w requires been sign should be	ted				10	Yes 2. No 3 Probably 4 □	]Unknown
ecc	- Q 10	Completed				24a. Was	psy prior to completion of	available cause of
E E	: The law cate has page 2 :	Con					ormed? death? 2 No 1 Yes 2 No	
of Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othor	ath (Check only		
o	Phys r this ral di	.: To	1 XYes 2 No 27. Manner of Death	1 Inpatient 2X PEH/Outp	ation: 3 DOA 4 Nursing P		idence 6 Other (Specify) how injury occurred	
O	ding F th. : After s funera	ition	1 ☐Natural 5 ☐ Pending 2 ∰Accident investigation	(Month, Day Year) Inj	me of ury 28c. Injury at Work?  13 P M 1 TYPES 2 NO	dwer	= much velvele	
Division	er dea	Certification;	3 Suicide 6 Could not determine	DB 280 Blood of Injury At home form		28f. Location ( City or To	Street and Number or Rural Route Nur	
Ö	tel or rs afte ei Dii			Shee	<i>t</i>	4800 360	that Hillenhod Mk	
	Hospi 4 hou Funer iely fil	edical	(Check only 2 Medical Exa	miner: On the basis of examination and/	death occurred at the time, date and place for investigation, in my opinion, death occurrence.	a, and due to the arred at the time,	cause(s) and manner as stated. date and place, and due to the cause(	s)
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Med	one)  29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)	
	F 3 F 8		I formand	12002 1-02 110	O.C.M.E.	1	May 4, 2004	
	01		30. Name and address of person who	completed cause of coath (Item 23a) (T		1		
	1		Tasha Z Gir	eenberg M.O.	•	, Baltir	more, Maryland 212	201
	Sta Registr	•	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sparks			

			1 - For State Registrer	of Maryland / Depa	artment of Health and Mattificate of Death		ene 2004	14913
35	Div1-1		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Madeline Eckman			May 6, 2	2004 Year	4:30 A M
1	Examin		4a. Facility Name (If not institution, give street and The Wesley Home	number)	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2XXF	7. Age (In yrs. last birthday) 102 yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Y May 24,	9. Birthpl Virg	ace (State or Foreign inia
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		10	Od. Inside City Limits
	Maryl	to	Maryland N/A	Baltimo	ore			1X Yes 2 ☐ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow or other traumatic event, the Medical Exable at must be notified at	i Director	10e. Street and Number 2211 W. Rogers Avenue		10f. Zip Code 21209	100	. Citizen of What Coun USA	try?
	death	Funeral		ecedent Ever in U.S. 13. \ Forces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
020	ours after al', or its Examine	þ	1 Never Married 2 Married 1 Yes	s XXNo	1 ☐ Yes 2 ☑ No Specify:		Canaifu	ite
ם כ	72 hc	Completed	15. Decedent's Education (Specify only highest grade complete	(Give	lent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/Ind	lustry
7	within ane. than	mp	Elementary/Secondary (0-12) Colleg Unknown	e (1-4or 5+)	lomemaker		Own Ho	me
7 0	Hygie Hygie Sther ent, II	ပိ	17. Father's Name (First, Middle, Last)	1.		e (First, Middle, Ma		ine
yiana	should be ind Mental marked o	To B	Andrew Shelton		Olive		The Town Chair Ti-	Code
, Mar	and 2 shealth and 127 is m		19a. Informant's Name/Relationship (Type, Print) The Wesley Home Guard	dian 2211	My Address (Street and Number or Aur W. Rogers Avenue	Baltimor	e, Marylan	d 21209
OLG	Pages 1: nent of He int: If iten iry or oth		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal fro		natory or other place)		oc. Location - City or To	
Sammor	t. Pa rtmen rtant:		* 4 □Donation 5 □ Other (Specify)  21. Signatur of Juneral Service License		t Cemetery   5/10 Name and Address of Facility Surgee—Henss—Seitz		Baltimore,	
ñ	Depa Impo any is		1 Jum 13-74	CNC-	6031 Falls Road, B	altimore,	Maryland	21211
	Physician		23a. Part1. Enter the disease, or complications the shock, officer failure. List only one cause of Immediate Cause (Final disease or condition	n each line.			t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	to (or as a consequence of):	e Denoution Vascular D'See	ne		
	ted nsit	Examiner	cause (Disease or injury	to (or as a consequence of):				
Ď,	be executed icien and burial-transit	Exar	that initiated events c	to (or as a consequence of):				
9/60	cate b	dicai	d					
O. BOX 6	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the buriat-transit	Physician/Me	23b. Was decedent pregnant 1 ☐ Lin in the past 12 months? 4 ☐ Pr		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
1S, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to	o death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to th	
Hecords	w requ been shoulk	letec	Y		3,00	24a. Was an	24b. Were autor	osy findings available
Ye.	sician: The law scertificate has E lirector, page 2 s	Completed				autopsy	prior to condeath?	npletion of cause of 2 No
VITal	ian: irtifica ctor, p	BeC	25. Was case referred to medical examiner?		26. Place of Deal	h (Check only one)		
> 	Physician: r this certific ral director,	70	1 ☐ Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatier			ce 6 ☐Other (Specify	)
VISION	nding Physath. r: After this e funeral di	ation:	27. Manner of Death  12 Accident  28a. Di  (N  2 Accident  28a. Di  (N  20a. Di  (N  20a. Di  (N  20a. Di  (N  20a. Di  (N  20a. Di  (N  20a. Di  (N  20a. Di  (N  20a. Di  (N  20a. Di  (N  (N  20a. Di	ate of Injury fonth, Day Year) 28b. Time o Injury	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
DIVIS	after des Directo	Certification:	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury · At home, farm, sti uilding, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: Atter this completely filled in by the funeral di	edical C	(Check only 2 Medical Examiner: On th		h occurred at the time, date and place, vestigation, in my opinion, death occur			
	within To the comple	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, I	Day, Year)
	•		> K.T. felet, n	W.	Dalkey		5/10/04	
	4		30. Name and address of person who completed of	ause of death (Item 23a) (Type,	Print) KST BATTI M	1. 7123	2-4	
	St Regist	ate	31. Date filed (Month, Day, Year) MAY 1 1 2004	2. Begistrar's Signature	Print) KST BALTO, M			
31	negisi	Tal	Well T T Foot					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** WOODROW EVANS MAY 20048. SOA pon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ELDER CARE
5. Social Security Number 6. Sex If Under Vear Honder 24 Hrs. BALTIMORE
9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 6 / 17 / 1920 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Days Months Hours Country) 83 220-01-5189 Director NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 Tyes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3829 PALL MALL ROAD 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 □ No f Yes, Give 1 Never Married > Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Completed by If Yes, Give Year or Dates: 1943-45 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) S.T.A. OF BA LONGSHOREMAN 11TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES EVANS GERTRUDE JONES ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOMMIE MAE EVANS 3829 PALL MALL RD, BALTO, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 5/14/2004 MARYLAND 21. Signatur Funeral Service License 22. Name and Address of Facility HOWELL FUNERAL HOME Fatt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, social of the cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final dia see or condition resulting in death) END Priysician STAGE PAN /Medical Due to (or as a consequence of): Examiner HARS DEMENTI Sequentially list conditions, Tany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes Division of Vital 21-No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Jaursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1\_Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Momicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2. To the F the 29b. Signature and title of certifier 29c. License number D00531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

6303

GUPTA

32. Registrar's Signature

A

SHAKUNMAL

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryl	land / Depa	artment of H	ealth and I Death		iene2 () <sub>19. No.</sub>	04	14915
	Physici		Decedent's Name (First, Middle, Last,	DOROTHY	<del></del>	EVANS		2. Date of Deat Month 05	h Dav	Year 04	3. Time of Death 3:45 A M
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		J	4c. County	of Death	
	Funeral Director		214-10-11//		yrs. last birthday) Yrs.	Annapol If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02/14/	Anne '1911		ndel place (State or Foreign ntry) MD
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  VA Warren		City, Town or Lo					1	10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23s or 28s	ral Director	10e. Street and Number 215 S. Royal Av	· · · · · · · · · · · · · · · · · · ·		10f. Zip Code 22630	aut vide diele		Og. Citizen of V	Vhat Cour	ntry?
920	urs after de al', or items	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Everi Armed Forces? 1 _Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2 X No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		k, White,	can Indian, etc. nite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show say injury or other traumatic event. The Medical Examinating runsi be notified at announce.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired,	ition furing most of wor )	king	16b. Kind of Bu	ısiness/Ind	dustry
land 2	ild be filed v lental Hygie 'ked other t ilc event, Ill	To Be Co	17. Father's Name (First, Middle, Last)  Albert Thane W	4 hite	Anal	yst		ne (First, Middle, M Rebecc		ө)	ment
, Maryland	and 2 shouealth and N m 27 is mer		19a. Informant's Name/Relationship (Ty Donna Oliva/Nie	pe, Print)	2425	g Address (Street a	nd Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)
Baltimore,	t. Pages 1 rtment of H rtant: If iter njury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	ayview	natory or other place Cremato	ry 5/1	1/2004	Balti	more	e, MD
Bal	Demi Depa Impo sny ir		21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or compli	cations that caused the d	1 1	69 Rivi	era Dri	ve Pas	adena	eral , MD	Home, PA
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  Due to (or as a con	A	Lenica					Interval Between Onset and Death
87602	cate be executed by physician and ithe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ciscate or Fjury that initiated events resulting in death) Last	Due to (or as a con							
.O. Box 68	The law requires that the death certifica tite has been signed by the attending ph bage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3 🗌	Ectopic pregnancy			23d. Date Mor	e of delive	ery Day Year
٥.	w requires that the bound by should be detained by	ed by Ph	Part II. Other significant conditions con	tributing to death but not	resulting in the un	derlying cause give	n in Part I.	23e. Did toba	_		ably 4 Unknown
al Records,		Completed						24a. Was an autopsy perform	ed? d	/ere autoprior to comeath?	psy findings available inpletion of cause of
Division of Vital	ling Phys	tlon; To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No H  27. Manner of Death ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	Nursing Ho	th (Check only one one 5 Residen 28d. Describe how	ce 6 □Othe		)
Divis	tel or Attancrs after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)			28f. Location (Stre City or Town,	State)		
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	one)	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occur	and due to the cau red at the time, dat	ise(s) and mar e and place, a	ner as sta nd due to	ated. the cause(s)
	To Ton		29b. Signature and title of certifier	Muse, ~	V	29c. License			d. Date signed		
	10		30. Name and address of person who by	ore 2108	tem 23a) (Type, F	Print) uner Dr	un U	or fer. 1	ns 2	161	9
A STATE OF	Sta Registra	-	31. Date filed (Month, Day, Year)	1 1 2004	Estar 1	1 Source	1				

		Department of Health and Mental   Certificate of Death	•
Physician /Medical Examiner	4a. Facility Name (If not institution, give street and number)  STARES HEALTHCA		4c. County of Death n/a
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 219–40–3902 1 M 2X F 61	Yrs.   April	f Birth, Day, Year)  29 1943  9. Birthplace (State or Foreign Country)  Maryland
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene tem 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Evarimer must be notified at TO Be Completed by Elinoral Director		Baltimore	10d. Inside City Limits 1 ☐ Yes 2 No  10g. Citizen of What Country?
us after death with the Mar ut, or Items 23e or 28a-1 sh rarriarer mest be coulffed.	2815 Florida Ave.  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	21227  13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	U.S.A.
0036 hours after turel', or ite	1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates:  15. Decedent's Education 1	1 ☐ Yes 2 ☑ No Specify:  6a. Decedent's Usual Occupation	Specify: white
21215-00 ed within 72 hou ygiene. ser than "natura it, tre Medical Et. tre Medical Et.	(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1-4or 5+)  8	(Give kind of work done during most of working life. DO NOT use retired)  Housewife	Homemaker
ryland hould be file d Mental Hy merked oth matic event	17. Father's Name (First, Middle, Last) George Bennett	18. Mother's Name (First, Min Helen Ag  19b. Mailing Address (Street and Number or Rural Route Ni	nes McCarthy
re, Ma	Richard Duncan Jr. (Son)  20a. Method of Disposition 20b. Place	3 Boulevard Place, Linthic of Disposition (Name of etery, crematory or other place)	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or any njury or other traumatic event, the Medical Evertage.		Cathedral Cemetery 05/08/C	
Physician	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	237 E. Patansco Ave.	Baltimore, Md. 21225  Approximate Interval Between
/Medical Examiner	PULM 414	24 EmBOLISM	Hour
8760, 8 at the be executed hysician and the burial-transit	that initiated events resulting in death) Last Due to (or as a consequent d.		DAYS
I Records, P.O. Box 68760, K. The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transitional physician by Physician Madinal Examilations.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel de 4 Pregnant at time of death 9 Unknown	eath 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
cords, P wrequires that been signed b should be deta		· • · · · · · · · · · · · · · · · · · ·	Did tobacco use contribute to the cause of death?
al Records, al Records, i. The law requires t cate has been signe cate has been signe connected by			Was an autopsy findings available prior to completion of cause of death?  as 2 No 1 □ Yes 2 No
of Vital F hysician: Th his cartificate I director, pag	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER.	26. Place of Death (Check of Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ F	nly one) Residence 6 □Other (Specify)
On on of ding P. After the funeral fun		ib. Time of 28c. Injury at 28d. Descri Injury Mork? M 1 ☐ Yes 2 ☐ No	ibe how injury occurred
Division  To the Hospital or Attentition 24 hours after dealt To the Funeral Director: completely filled in by the			on (Street and Number or Rural Route Number, Town, State)
To the Hosp within 24 hou within 24 hou completely fill	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigation, in my opinion, death occurred at the ti	me, date and place, and due to the cause(s)
T WE STORY		29c. License number P = 15632	29d. Date signed (Month, Day, Year)  MHY 5 2004
P	30. Name and address of person who completed cause of death (Item 23		
State Registral		Sparks	LTIMORE, MD, ZIZZ9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 7:02 PM ma /Medical May 06 4005 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner 5. Social Security Number 3. Sex 7. Age (In yrs. last birthday)
1 M 2 F 83 Yrs. If Under 1 Year If Under 24 Hrs. 8. Da 8. Date of Birth (Month, Day, 6. Sax 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 12-9608 Director 19 Usual Residence of Decedent death with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28e-f show Examiner aust be notilled at Maryland 1 Yes 2 □ No Completed by Funeral Director more 10e. Street and Number 3325 10f. Zip Code 10g. Citizen of What Country? 2 121 mon 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If Item 27 Is marked other then "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lechnician . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be lar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Importent: If It any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 12004 em re of Funeral Service License Joseph L. Russ Funeral He 2222 W. North Ave. Balto. Hom 21216 23a. Parti. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shopt, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MOXIC Physician disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a consequence of Physician/Medical Examiner burial-transit The faw requires that the death certificate be executed みの Due to (or as a consequence of) physician sthe burial Box 68760. IE FEMALE . If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) detached 9☐ Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 T DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident within 24 hours after death. To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and 29d. Date signed (Month, Day, Year) 037343 y who completed cause of death (Item 23a) (Type, Print) HEIGHTS AVE. BALTIMORE MODDIST 2600 MORGAN, MID LIBERTY

Registrar

DHMH 17 Rev 1/2001

State

MAY 1 1 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MH5.

	4	For State Registrer AMEND LIFM #5 #	State of Maryland  30 perfh &30 per	dvr Ce	artment of H 31.5/11/04 rtificate of L	ealth an H Death		giene Reg. No.	2004	14	918
Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day		3. Time	of Death
/Medica	al -	RONNIE PAUL	and and an book		EHRLICH	Location of D	MAY		2004	4:30	P
Examine	er	4a. Facility Name (If not institution, give 2409 SUNSHINE WAY			4b. City, Town, or  GAMBRILL:  If Under 1 Year	_	7	AN	County of Deat	NDEL	
Funeral Director		5. Social Security Number 6. Sec. 15. 227 - 42 - 1600	7. Age (In yrs. la	• • •	Months Days		Min. (Month, Da)	y, Year)	9. Bin	hplace (State untry) INDI/	
		Usual Residence of Decedent									
show ed at	2	10a. State 10b. County		, Town or Lo						10d. Inside (	s 2∏No
death with the Maryland	Director	MD ANNE ARUI	NDEL GAM	BRILL	10f. Zip Code	-		10g. Citiz	zen of What Co	<u></u>	X
3a or		2409 SUNSHINE WAY			21054			U.S	. Δ	,	
or Itams 23a	Funeral		12. Was Decedent Ever in U.S Armed Forces?	6. 13.	Was Decedent of Hi	spanic Origin' n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		14. Race - Ame Black, White		
be filed within 72 hours after death with the Maryla ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, Ita Madical Exemiter must be nutified at	by Fu	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes A☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ∏ No	Specify:	,		Consider	HITE	
within 72 hours ene. than "natural",		15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occupa	ition	working	16b. Kir	nd of Business/	Industry	
han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	)	-				
e filed val Hygiel other ti		12 17. Father's Name (First, Middle, Last)		COLLE	CTIONS	18. Mother's	Name (First, Middle,		IERICAL Sumame)	COLLEC	CIION
id be id be id be id be id be or id be	o Be	SAM	r	HRLIC	ц	FTHFI	(		•	RONOFF	
s 1 and 2 should be f Health and Mentai item 27 is marked o other treumatic ev		19a. Informant's Name/Relationship (Ty					r Rural Route Numbe	er, City or			
and 2 lealth a m 27 is		SANDY EHRLICH / WI	FE		SUNSHINE	WAY (	GAMBRILLS,		21054		
8°= 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 🕉 ☐ R	emoval from State	metery, crei	sition (Name of matory or other place		Date		cation - City or	Town, State	
t. Pages tment of rent: ff it		*4 □Donation 5 □ Other (Specify)	BET		AEL CEMETI		AY 8,2004		MPA, FL		
permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Lices	To use				SOL LEVINS N RD. PIKE				
		23a. Part. Enter the disease, or complished, or heart failure. List only or	cations that caused the death.						LE MU 2	Approxima	ate
าเงอใจโลก		Immediate Cause (Final disease or condition			StryThis					Interval Be Onset and	
/Medical		resulting in death)	Due to lor as a consequent		1	^					
xaminer		Sequentially list conditions,	Coroma	14	Hetey,	0186	ASE				
isi -	ulue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	enc∉ot):							
dding physician and	Exam	that initiated events resulting in death) Last	Due to (or as a consequent	ence of):							-
physician and the burial-transit	dlcal	Ų,	l								
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ter .	lan/Me	in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal • 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of deli Month	very Day	Year
y the	hysici	1 Ures 2 No 9 Unknown	9□ Unknown	aui J							
d de d	by Pr	Part II. Other significant conditions cor	tributing to death but not resul	lting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco u	se contribute to	the cause of	death2
en sig	leted t			<del></del> .			_ 1 D Y	′es 2[	No 3∏Pr	obably 4 🖟	Onknown
the taw returned the has be bage 2 sho	plet						24a. Was	sy		topsy findings	s available cause of
	Comple							med? 2 No	death? 1 ☐ Yes	2□ No	
certifi	Be	25. Was case referred to medical examiner?	lospital:		Othe	AC.	Death (Check only o			-	
r this certific eral director,	. To	1 Yes 2 No	28a. Date of Injury	P/Outpatier 28b. Time o	f 28c. Injury	at Nursir	ng Home 5 Pesid 28d. Describe h			cify)	
ath. r: Afte e fun	atlo	1 ②Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work M 1□1	?? ∕es 2 □ No	1				
to the respite or Attending Frys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, sti	reet, factory, office		28f. Location (S City or Tow			ral Route Nu	mber,
urs af											
24 ho Fune stely f	Medical	29a. Certifier (Check only one)  1 Certifying Physical Certifying Physical Examination (Check only one)	sicien: To the best of my know ner: On the basis of examinati and manner stated.	on and/or in	n occurred at the tim vestigation, in my op	e, date and p sinion, death o	lace, and due to the o occurred at the time, o	date and	and manner as place, and due	to the cause	(s)
outhin outhin comple	Me	29b. Signature and fittle of certifier	Ω		29c. License	number		29d. Date	e signed (Month	n, Day, Year)	
->-0		Din	puter MD		D49	5019		05	108/04	1	
01		30. Name and addless of person who co	impleted cause of death (Item		Print)	,	te Blud	)	77	Ä	
\		John Haved	martin	, ,	10 Cory	polal	e Bud	7	le 10	0	
Stat	e ar	Date filed (Month, Day, Year)	32. Registrar's Signati	ure	1						

		1 - For State Registrar	_	viarylan		artment tificate			ind M	ental Hyg  Re  2. Date of Deat	g. No. 20	04	14910
Physicia /Medic Examin	al	Decedent's Name (First, Middle, La.     Ceraldine V. Fris  4a. Facility Name (If not institution, giv.)	sbie	ər)		4b. City, To	own, or	Location of	f Death	Month 4/13/04		Year of Death	3. Time of Death 4:40 am <sup>M</sup>
Funeral	er	Kingshire Manor Nur  5. Social Security Number 6. S	sing Home	Age (In yrs.	last birthday)	If Under 1	Rock (	rille If Under 2 Hours		8. Date of Birth (Month, Day,	Mond Year)	tgamer	Y lace (State or Foreign try)
Director		099-28-2879         1           Usual Residence of Decedent         10a. State           10b. County		83 10c. Cit	Yrs. y, Town or Lo	cation				07/07/1	920		Od. Inside City Limits
r 28a-f sho	Director	MD Mor	ntgamery			10f. Zip C		ockvi1	le .	10	g. Citizen of W	hat Coun	1 ☐ Yes 2 <b>XX</b> 90 try?
iffilmore, Maryland 21213-0036  nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Heath and Mental Hygiene.  ortant: if item 27 is marked other than "natural, or items 23e or 28e-f show injury or other traumatic event, the Medical Exercities rotat be multiled at it.	Funeral D	9701 Medical Cente	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Decede	nt of His	20850 spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)		- America	an Indian,
hours afte tural; or It	þ	1 □ Never Married 2 □ Married 3 ₩ Widowed 4 □ Divorced  15. Decedent's Ex	1 □ Yes XI If Yes, Give Year or Date:	_		1 □ Yes <b>xi</b> ient's Usual	☑ No	Specify:			Specify:		White
Z1Z15-0U36 d within 72 hours aff giene. er than "natural; or the Medical Exem	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12		or 5+)	(Give	kind of work DO NOT use Dental I	done di retired)	uring most	of worki	ng	ob, raile of bes		istry
Maryland 212 of 2 should be filed within th and Mental Hygiene. 27 is marked other than traumatic event, the Me	To Be (	17. Father's Name (First, Middle, Last, Zignund Przelina						_	's Name tori	(First, Middle, Ma a Thrun	laiden Sumame	)	
S, Mar and 2 sho tealth and m 27 is m her traum		19a. Informant's Name/Relationship ( Kathleen L. Hannon				artha O	stis		, Ale	/Route Number, exandria V ate	A 22302		
Baltimore, permit. Pages 1 at Department of Hea Important: if item any injury or othe		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification of Company of Expense) Sequence of Expense o	v)	te Cla	rence Fi	11more	er place Ceme	tery	411	7104	Clarence		Y <sup>1</sup>
Departmine Departmine Departmine Departmine Department		21. Signature of Funeral Service Licer  23a. Part1. Enter the disease, or comshock, or heart failure. List only	<b>&gt;</b>	-	-	1501 Ez	L. S	tevens	Fune	eral Home, Baltimor	MD 2123	00	Approximate
Physician /Medical Examiner	ner	shock, or heart failure. List only transdate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a conseq	MCC uence of):	dS	<u>De</u>	men	aq				Interval Between Onset and Death
BOX 68 (b);  Jean to certificate be executed  rattending physicien and dror use as the burial-transit	/Medical Examiner	resulting in death) Last  IF FEMALE:	c	as a conseq									
HECOTOS, P.O. BOX BS The law requires that the death certifica tie has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of d	Ideath 3	Ectopic preg Other (spec					23d. Date Mont		Y Day Year
COLDS, P. requires that been signed I should be det	by	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying cau	ise give	n in Part I.		m _			e cause of death?
	Completed									24a. Was ar autopsy perform 1 Yes 2	ed? de	ere autop of to com ath? Yes	sy findings available apletion of cause of
VISION OF VITAL HY Attending Physician: The r death. ector: After this certificate his by the funeral director, page	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No  27. Manner Death  1 □ fatural 5 □ Pending investigation			ER/Outpatien 28b. Time of Injury		Othe Unjury Work	G 4 - Mur	sing Hon	(Check only one ne 5 Resider	nce 6 Other		)
DIVISION tal or Attending s after death. e) Director: Afte ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of	Injury - At ho etc. <i>(Specif</i> )		eet, factory,	office		2	28f. Location (Str City or Town,		r or Rural	Route Number,
DIVISION O  To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After completely filled in by the funeral	Medical	(Check only 2 Medical Exar	ysician: To the be niner: On the basis and manner	of examina	wledge, death tion and/or inv	estigation, in	т ту ор	inion, death	place, a	ed at the time, da	te and place, ar	nd due to	the cause(s)
To with To Con	~	29b. Signature and transfer certifier	m	in	)	De	50	S85	59:	7	d. Date signed	(Month, D	yay, Year)
P		30. Name and address of person who Sharry ar Do 31. Date filed (Month, Day, Year)	avarim					Spra		MD 200	27 /40	1 13	

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

			1 - For State	State of Maryland / Depar	tment of Health and ificate of Death	Mental Hy	2004	14920
			Registrar  1. Decedent's Name (First, Middle, Last)	- OGT	incate of Death	2, Date of D	Reg. No.	3. Time of Death
	Physici		DOMINICK	FOWL	KES	Month	O4, 2004	2108 4
j.	/Medic Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dea	-	4c. County of Death	
			The Johns Hop	olgines Hospitian	Bottineuse C	city		
H	Funeral Director	50	1771-04		If Under 1 Year If Under 24 Hrs Months Days Hours Min		irth Yar) 9. Birthol	lace (State or Foreign try)
	and and		Usual Residence of Decedent  10a, State 10b. County	10c. City, Town or Loca	ation		1 10	0d. Inside City Limits
	n the Maryland r 28a-f show notified at	ctor	MD	Baltin	nore			1 <b>№</b> 6 2 No
		Funeral Director	608 F: 36H	Street	21218		10g. Citizen of What Coun	try?
	itams	Iner		Was Decedent Ever in U.S.     Armed Forces?     If N	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	Specify Yes or N to Rican, etc.)	lo- 14. Race - America Black, White, e	
030	to of	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo	Yes 2 No Specify:		Specify: R/	ack
ဂ ဂ	72 hours "natural", Idical Exe	etec	15. Decedent's Educ (Specify only highest grade	completed) (Give kii	nt's Usual Occupation nd of work done during most of wo	orking	16b. Kind of Business/Ind	fustry
7 7	within iene. than	Completed	Elementry/Seepndary (012)	College (1-4or 5+)	O NOT use retired)	·	N/A	
	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)	0	18. Mother's Na	me (First, Middle	e, Maiden Sumame)	
<u>Z</u>	Ment Ment arkac	10	DOMINICK F	owlkes SR.	Crys	stall.	Byers	
<u>a</u>	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Name/Relationship (Ty)		Address (Street and Number or R	ural Route Numi	ber, 🐪 or Town, State, Zip	Code)
e)	s 1 and f Healtl itam 27 other 1		20a. Method of Disposition	1 Kes SR. (Faller) 60,	tion (Name of	Date	20c. Location - City or To	wn. State
5	ages int of t: if it		1 Surial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)			liday	Baltinore.	ALD.
	nit. Partme		21. Signature of Puneral Service License		Name and Address of Family	11907	-	1
ñ	permit. Depart import any in		1 Vaupu C.	freme 3	ant Dork	pad Bo	weral Sera	4 mm 4
	1		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do not enter	100 4-0-7	c or resmratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	cerchaleden	ia and her	niatio	· • • • • • • • • • • • • • • • • • • •	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	are 10000 11001	10100110	. 1	- //
	LAGIIIIICI	<u></u>	Sequentially list conditions,	Due to (or as a consequence of):	PAIN INJURY		1	4hours
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Õ	certificate nding phys	Med	IF FEMALE:			W	23d. Day of deliver	
X O D	that the death certificated by the attending posterior of detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ctopic pregnancy	J		ry Day Year
	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ C 9 ☐ Unknown	Other (specify)		<b>WALLEY</b>	,
ī.	w requires that the s been signed by the should be detache		Part II. Other significant conditions con	tributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did	topuco use contribute to the	e cause of death?
Hecords	quires n sign uld be	ed by	MandiBURAR FRA	CTURE, LIVER LACE	RATION	1	es 2□No 3□Proba	ably 4 Unknown
ပ္သ	> 0 0	ompleted		,		24a. Was		sy findings available
	The late ha	mo:				auto perf	ormed? death?	pletion of cause of 2 No
VII	ystcian: The laviscentificate has director, page 2	BeC	25. Was case referred to medical examiner?		26. Place of De	ath (Check only	1	<i>P</i>
010	S S	2	1 XYes 2 No H	ospital: 1 Inpatient 2 ER/Outpatient			idence 6 Other (Specify,	)
	ding F	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2 No	28d. Describe	how injury occurred	
UNISION	Attending ir death. actor: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stree		28f. Location	(Street and Number or Rural	Route Number.
2	al or / s after t Dira	Certificati	4  Homicide	building, etc. (Specify)	,	City or To	own, State)	
	To the Hospital or Attending Phwithin 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	ledical (	29a. Certifier Certifying Phys	icien: To the best of my knowledge, death o er: On the basis of examination and/or investant and manner stated.	occurred at the time, date and place stigation, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as sta , date and place, and due to	ated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	7	29c. License number		29d. Date signed (Month, D	
	1			TECLOCY  Inploted cause of death (Item 23a) (Type, Pri  SLEY, MD GOON, Co  32. Registrar's Signature	RES-OC	<b>,</b>	MAY 4.2	004
	ĥ		30. Name and address of person who co	repleted cause of death (Item 23a) (Type, Pri	int)			
	J		R. BLAINE EAS	SLEY, MD GOON. W	DOLFIE STREET, B	actimor	E, MD 21	287
	Sta	ite	31. DM ДА (Montil, Dan Year)	72 32. Decistral & Signature	and a		•	

Registrar
DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryl		artment of F		nd Mental H	ygiene Reg. No	2001	, 11,	921
I	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of I Month		ıy, Year	3. Time of	
1	/Media	cal	Mildred M.	Franey		4h City Taylor	-1	May		4, 2004	10:21	РМ
	Examir	ner	4a. Facility Name (If not institution, give Greater Baltimore		iter	4b. City, Town, o	r Location of	Death	1	c. County of Death $a1 { t timore}$		
	Funeral		Social Security Number     6. Security Number	7. Age (In)	rs. last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of E	Birth	9 Birth	place (State o	r Foreign
	Director		1/9-38-1342	□M 2434F   86	Yrs.	Months Days	Hours	Min. April	14,	1918 PA	ritry)	
	and w		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	cation					10d. Inside Cit	ty Limits
	Maryi -f sho lied a	tor	NJ Burlingt	on	Ma	arlton					1 ☐ Yes	2 XNo
	n the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Cou	ntry?	
	th wit	al D	129 Brick Road			08053				U.S.A.		
	er dea	nue	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Ameri Black, White,		
36	rs afte	by F	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🏋 No	Specify:			Specify:	white	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show he Medical Examination confilled at	ted	15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occup	ation	of working	16b. K	(ind of Business/Ir	ndustry	
7	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	or working	0.	wn Home		
2	iled w Hygiel thar ti nt, th	Col	12 17. Father's Name (First, Middle, Last)		поі	nemaker	18 Mother	's Name (First, Midd				
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Heath and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Its Mychole Erain actinust for collical at	To Be	Linford Mease					Campbell		,,		
ary	shou and M s mar	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street		or Rural Route Num		or Town, State, Zij	Code)	
	as 1 and 2 of Health of Health litem 27 I		Mrs. Catherine Rot						1			
Baltimore,	Pages 1 nent of Hi int: If iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	P.	fay 7	1	ocation - City or T		
ij	Pa ant ary		*4 ☐ Donation 5 ☐ Other (Specify  21. Signature Funeral, Service Licen			Neumann C		2004		alfont,		
Ba	permit. Departr Imports any inju		Protice (	2000-1				Singleton S.W., Gle				
	19		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the cone cause on each line							Approximate Interval Bety	yeen
	Pnysician :		Immediate Cause (Final disease or condition	MRSH	Pnec	emonia					Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or as a con								
Ų	TV: T	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence of):				_			
	cuted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
,0	ate be executed obysician and the burial-transit	I Exa	resulting in death) Last	Due to (or as a con	sequence of):							
8760,	cate b physic the b	Physician/Medical	•	d								
Box 6	certifi nding use as	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre						23d. Date of deliv	erv	
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	iclai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		]Ectopic pregnancy ] Other (specify)	···			Month		ear
P.0	at the d by th etache	Phys	9 Unknown					00. 5				
	signed bed		Part II. Other significant conditions on Part Lin Som	0 '	_	nderlying cause giv	en in Part.			use contribute to t	ne cause or de pably 4 ⊟U	1
Records,	w requir been si should	Completed by	7.07					24a. Wt		24b. Were auto	onsy findings a	vailable
Re	The ta te has age 2	omp						aut	topsy formed?	prior to co death?	mpletion of ca	use of
of Vital	ian: ] rtifical	BeC	25. Was case referred to medical				26. Place o	of Death (Check only		1 105	2010	
) \	Physician: this certificanal director,	2	examiner? 1 Yes 2 No		2 ☐ ER/Outpatien		4 🗆 Nuis	sing Home 5 Re			(y)	
on c	Jing P	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 ⊡ No	28d. Describe	e how inju	ry occurred		
Division	I or Attanding after death. Director: After I in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A	At home, farm, str		103 2 114	28f. Location		nd Number or Rura	al Route Numb	)e <i>r</i> ,
Div	s after	Certification:	4 Homicide	building, etc. (Sp	ecify)			City or T	own, State	e <i>)</i>		
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		(Check only 2 Medical Exam	ysician: To the best of my iner: On the basis of exam	knowledge, death	occurred at the tin	ne, date and pinion, death	place, and due to the	e cause(s	) and manner as s	tated. the cause(s)	
	thin 2 the i	Medical	29b. Signature and title of certifier,	and manner stated.		29c. Licens	e number		29d. Da	ite signed (Month,	Dav. Year)	
	± 3 ± 8		1 Breach	den us	0			3489		- /	-104	
	10	}	30. Name and address of person who	4	Item 23a) (Type,	Print)	•	189 m			/ /	
				rarles J	4 60	1 Ba	Chn	une his	D	21204	/	
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1 1 2004	32. Registrar's S	4 4	all is						
	riogisti	-ĢII	MIDI I I ZUU4	Marie L	r popol	ras						

			For State Registrar	State of M	arylan	_	artment rtificate			and M		giene Reg. No	200		11.020
	Physici	an.	1. Decedent's Name (First, Middle, Las	t)							2. Date of De			3. T	ime of Death
	/Medic		Vernon K. Frech								May		4 2004		:00P M
	Examir	er	4a. Facility Name (If not institution, give Millenium Nursing	•			4b. City, 1						. County of Dea	ith	
	Funeral		5. Social Security Number 6. Sec		e (In yrs. i	last birthday)	LII:	1 Year	t Cit		8. Date of Bir	th	Howard 9. Bir	thplace /	State or Foreign
	Director		215-30-1598	XIM 2□F	7	1 Yrs.	Months	Days	Hours	Min.	Feb. 8	v. Year	3 Mai	ountry) Cy1an	State or Foreign
	pun *		Usual Residence of Decedent  10a. State 10b. County		10c Cib	, Town or Lo	oation		•					104 1-	
	Maryle f sho	ō	Maryland Baltimo	22.0	700. 01.			1 -						1	ide City Limits Yes 2√∑ No
	28a-	Directo	10e. Street and Number	re		Cato	10f. Zip					10a. Ci	tizen of What Co		
	h with		123 Glenmore Av	enue				212	228			_	U.S.A.		
	ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. \	Was Decede	ent of His	panic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ame Black, Whi		ian,
36	s afte	by Fu	1 ☐ Never Married 2 🔁 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ I If Yes, Give	No		1□Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	moon, olon,		0	nite	
Ö	72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show idical Exertiner must be notified at		15. Decedent's Ed	Year or Dates:		16a. Deced	lent's Hsual	I Occupat	tion			16b K	ind of Business		
15	nin 72 In "ins Medis	plet	(Specify only highest gra	de completed)		(Give	kind of work OO NOT use	k done du		of working	ng	100.10	and or Dusiness	villoustry	
7	filed within Hygiene. other then "	Completed	Clementary/Secondary (6 12)	College (1-4or s	,**)	Mecha	anical	L Eng	ginee	r			Buildin	g	
nd	d tal	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
yla		၉	Karl Frech	D. (4)			-				Hazensa				
Maryland 21215-0036	d 2 s h ar 7 is trau		19a. Informant's Name/Relationship (7 Dorothy M. Frech	уре, Рппі)									or Town, State, . Maryla:		
ē,	s 1 and 2 if Health itam 27 i		20a. Method of Disposition		20b. P	ace of Dispo	sition (Nam	e of		Water and the same	ate		ocation - City or		
9			1 Burial 2 □ Cremation 3 □  1 4 □ Donation 5 □ Other (Specify		1	emetery, cren Pau1's	-			5-8-	2004	lio1	etville	Mai	cvland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	9/	0								ville,		June
8	8258		Deman K	between	tre	16	30 Ea	imond	lson .	<u>Aven</u>	ue Cato	nsv	ille, M	D 212	228
			23a. Part1. Enter the disease, or compositions and composition of heart failure. List only of	dications that caused one cause on each li	10.						_	rrest,		Interv	ximate al Between t and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Cė	reb	word.	seule	~	Aca	etde	mi			4	2345
	Examiner			Due to (or as	a consequ	uence of):	ash.	. (	W	desc	ease			4	oen.
	4	er	Sequentially list conditions, if any, leading to inmediate	b. Due to (or as			1010			1134	ase				- J.
	cuted id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
Ö,	sician and burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):									
8760,	at Se	Physiclan/Medical		d					-						
9	death certifica attending pt d for use as t	/Me	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv							20d D-A6 d-1		
Вох	death atten	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3 [	Ectopic pre Other (spe						23d. Date of del Month	Day	Year
o.	at the de by the a tached	hysi	9 Unknown	9□ Unknown				,,							
s, p	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions of			liting in the ur	iderlying cai	use given	in Part I.		23e. Did to	obacco u	ise contribute to	the caus	e of death?
ord	w requir been si should		Der	nentic			_				101	/es 2	□No 3□Pr	obably	4 Unknown
of Vital Record	law as b	ompleted									24a. Was autop	SV	prior to	topsy find	dings available n of cause of
al H	ate pag	0									perfo 1 ☐ Yes	rmed? 2 No	death? 1 ☐ Yes	2 🗆 N	o
ZIE.		o Be	25. Was case referred to medical examiner?	Hospital:				Other	1-		(Check aniv a		_	37.50	
	ig Phys ter this neral di	les 1	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry	ER/Outpatient 28b. Time of		c. Injury a	at Nur		ne 5 ∐ Resid 8d. Describe h		6 □Other (Spector)  y occurred	city)	
ion	를 구 후 들	atlo	1 Natural 5 Pending investigation	(Month, Day	/ Year)	Injury	М	Work?	s 2□N	10					
Division	l or Atten after deat Director: I in by the	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At ho	me, farm, stre	et, factory,	office		2	8f. Location (S City or Tox	Street an vn. State	d Number or Ru	ıral Route	Number,
Ω	Hospital or At 4 hours after of Funaral Directely filled in by	0		1									,		
	d 4 h	edical	29a. Certifier Certifying Phyone) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examinat	vledge, death ion and/or inv	occurred at estigation, i	t the time in my opir	, date and nion, deat	i place, a h occurre	nd due to the d d at the time, d	cause(s) date and	and manner as place, and due	stated. to the ca	use(s)
	To tha Hos within 24 hy To tha Fun completely	Med	29b. Signature and the of certifier				29c.	License	number			29d. Dat	e signed (Monti	h, Day, Ye	ear)
	1		· Mall	K ATT	end	ing M	0	05	070	)3		5	1410	4	
	b		36 Name and address of person who o		eath (Item	23а) (Туре, Г	Print)			0 1			2 :	320	) .
	** - O		31. Date filed (Month, Day, Year)	Achdet 32. Registra	r's Signat	105 ure	Tre	doi	nul	red	ste	16	4,21	228	· ·
4.E	Sta Registr		MAY 1 1 200		معم	6	Spa	121							

			. For	State of Marylan	d / Department of Health and N	Mental Hygiene 201	11, 11,923
		_	= State Registrar		Certificate of Death	Reg. No.	14723
8	Physicia	an	Decedent's Name (First, Middle, La	St)			3. Time of Death
A SE	/Medic Examin		4a. Fecility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of Death		
	LXamm	~\ -\	University of	Maryland Ho	said Baltimore	N	lA.
П	Funeral		5. Social Security Number 6. 5	Fex 7. Age (In yrs. I	ast birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Gountry)
-	Director		Usual Residence of Decedent	×   30		1100.6,171311	viaryjana
	how Int		10a. State 10b. County	10c. City	, Town or Location		10d. Inside City Limits 1 XYes 2 □ No
	the Ma	Director	Varyand N	A	Salt More 101. Zip Code	10g. Citizen of Wh	
	3a or		71/2 Brune	St	21201	U	SA
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puento	pecify Yes or No-	American Indian, White, etc.
36	hours after death with the Maryland turel, or Items 23s or 28s-f ehow at Executing fount be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗵 No Specify:	Specify:	Dlack
21215-0036	natural',		15. Decedent's E	ducation	16a. Decedent's Usual Occupation	16b. Kind of Busi	ness/Industry
215		Completed	(Specify only highest grant (0-12)	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	king	1/ 2
	be filed within 72 ho ntal Hygiene. od othar than "natur event, Ina Medical		17. Father's Name (First, Middle, Last		DOMESTIC 18. Mother's Nam	ne (First, Middle, Maiden Sumame)	ekeeping
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M	To Be	Walter Jo	hnson	Mar	v Allen	
ary	ges 1 and 2 should t of Health and Men if Item 27 is marke or other treumatic	_	19a. Informant's Name/Relationship	Type, Print) (daughter)	19b. Mailing Address (Street and Number or Ru	ral Route Number, City or Town, St	ate, Zip Code)
	is 1 and 2 of Health Item 27 other tre		MS. Joyce (	oreen 200 B	lace of Disposition (Name of	Date 20c. Location - Ci	21201
altimore,	Pages 1 nent of H int: if ite		20a. Method of Disposition  1 Burial 2 Cremation 3 Communication 3 Communication 5 Communication 3 Communication 3 Communication 3 Communication 5 Communication 3 Communication 5 Communicati	Removal from State	emetery, crematory or other place)	12004 A-1	has Md
altin	nit. artm orta inju		* 4 □ Donation 5 □ Other (Special Service Lice	Control of the Contro	22. Name and Address of Facility	711 000	45,1110.
ä	Depa Impo eny i		1 Joseph	J. Kus	1 Joseph Likuss 2222 WiNorth A	runeral Home ve. Balto. Mo	1.21216
			shock, or heart failule. List onty	pplications that caused the death one cause on each line.	n. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate fnterval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pulmo	nay Embolism		minutes
В	Examiner		ſ	Due to (or as a consequence of the consequence of t	nay Embolism uence of): all cell lung can		14 mante
	P #	ner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):		71.06.1183
	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of):		
760,	te be executed ysicien and te burial-transit	calE		200 10 (01 20 2 0011004)	30,00 01).		
68	~ ~ ~			0.			
Box	ith cer itendin or use	Physician/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	death 3 Ectopic pregnancy	23d. Date of Month	
-	that the death cer ed by the attendir detached for use	yslcl	1 ☐ Yes 2 ANo 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5 Other (specify)		
, P.O	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	by Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?
Records,	w requires that s been signed t should be deta	ed b	Chronic	heart t	alue	1 Yes 2 No 3	Probably 4 Unknown
ecc	law renas be	Completed	Chronic	renal insu	Ficiency	autopsy pric	ere autopsy findings available
a B	sician: The law certificate has b irector, page 2 s			T	•	1 Yes No 1	ath? Yes 2/2/No
Vital	Physician: The this certificate hiral director, page	To Be	25. Was case referred to medical examiner?  1Æ4¥es 2□ No	Hospital: 1 Inpatient 2	Other	th (Check only one) ome 5 Residence 6 Other	(Specify)
اه ر	ਲ ≑ ਲ	n: T	27. Manner of Death  1 Naturel 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work?	28d. Describe how injury occurred	
sior	leath. for: Af the fur	catlo	2 Accident investigation 3 Suicide 6 Could not it		M 1 Yes 2 No	201	
Division of	I or Att	Certification:	4 Homicide determined		ome, farm, street, factory, office	28f. Location (Street and Number City or Town, State)	or Hurai Houte Number,
_	To the Hoepital or Attending Phwithin 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	alC	29a. Certifier Certifying P	hysician: To the best of my kno	wledge, death occurred at the time, date and place	, and due to the cause(s) and mann	ner as stated.
	the Ho nin 24 the Fu	Medical	one)	and manner stated.	tion and/or investigation, in my opinion, death occu		
	To To con	-	29b. Signature and title of certifier	Attending Ph	1510am DANELS	29d. Date signed (	)
	1		30. Name and address of person who	completed cause of death (Item	1 23a) (Type, Print)	10 May	5# 2004
			Marcia A. Cort	, mb 22-5: 6	29c. License number  D 005624  D 23a) (Type, Print)  Scene 5t, Brethmore	ND 21201	
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 1 2004	32. Registrar's Signa	D spailst		
	negisti	al .	MAT L L ZUU4	/ /	• /		

UNK 04-159	Р	lease Type or Pr					•	ible.
04-02982	for State Registrar	State of N	Maryland / Dep	artment of t		-	-	101 11 001
RPD	Registrar  1. Decedent's Name (First, I	Middle, Last)	Ce	Tuncate of	Dealli	2. Date of De	Reg. No. 2	3. Time of Death
Physician	Todo	L.		Hall		May 2	2004	Year 0515 A M
/Medical	4a. Facility Name (If not inst	itution, give street and number	r)	4b. City, Town, o	or Location of Death		4c. County	of Death
	Johns Hopkin			Baltimo				NA .
Funeral Director	5. Social Security Number 215–86–6059	1 XM 2□ F	Age (In yrs. last birthday, Yrs.	Months Days		8. Date of Birt (Month, Da 6-2-7	th ly, Year) O	9. Birthplace (State or Foreign Country)  Md.
/land	Usual Residence of Decede 10a. State 10b. Co		10c. City, Town or L	ocation				10d. Inside City Limits
Many a-f sh	Md.	NA	Baltim	ore				1 <b>X</b> Yes 2 ☐ No
or 28	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?
s 23a	4200 Shamr	ock Ave.		21206		77.14	USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show string injury or other treumatic event, the Medical Evanuer must be required at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2  3 Widowed 4 Dive		s? XNo	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specil	ce - American Indian, ck, White, etc. <sup>(y:</sup> Black
2 hour nature load E	15. Dec	edent's Education nighest grade completed)	16a. Dece	dent's Usual Occup	pation during most of work	kin a	16b. Kind of B	usiness/Industry
21215-0036 ed within 72 hours alt ygiene. "rethen "naturel", or it, the Medical Frant. Completed by F	Elementary/Secondary (0		ir 5+)	DO NOT use retire	ed)	king		
L21 lied w tygier the tit.		iddlo ( ast)	Folk	Lift Ope	erator 18. Mother's Nam	o /First Middle		Poultry
Maryland to 2 should be file the and Mental Hy 27 Is marked oth treumstic event To Be (		Stephen	Hall		Constai			oldring
Iryla Should I ad Meni marke imatic o	19a. Informant's Name/Rela				t and Number or Rus			
Ma nd 2 : alth ar 27 Is r treu	Nicole Hall	. Sis		-	Ave., Ba			21218
or Her item	20a. Method of Disposition		20b. Place of Disp		1	Date		City or Town, State
Baltimore, Peemit. Pages 1 a Department of Hee miportant: If titem mortant: If titem any injury or othe ance.	1 ☐ Burial 2 ☐ Crema  1 ☐ Donation 5 ☐ Oth	ition 3 □Removal from Stat er <i>(Specify)</i>	(9	em. Pk.		0-04	Randal	lstown, Md.
Balt permit. Depart Import	21. Signature of Funeral Se	rvice Licensee	2	2. Name and Addre	ess of Facility	Baltimo	ore, Md.	21202
<b>™</b> &∆5 € ₹	1 flelso	May		arch F.H.			North	Ave.
3760, ate be executed system and he burial-transit lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a			wo upos			Interval Between Onset and Death
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Vision Attending ar death. ector: After by the fune	2 Accident in	vestigation 5/2/04	3:24		Yes 2 No	SVBTECT	WAS	SHOT
S page	3 ☐ Suicide 6 ☐ C 4 ☐ Homicide	building,	njury - At home, farm, st etc. (Specify) LOE RESIDE	* '		City or Tow	Street and Numb vn, State) 9HROW	Per or Rural Route Number,  AVE BALTITURE MI
Lithin 24 hospital thin 24 hours is the Eunerel impletely filled	29a. Certifier 1 Cer (Check only 2 Mer	rtifying Physician: To the besidical Examiner: On the basis	of examination and/or in	th occurred at the tinvestigation, in my o	ime, date and place, opinion, death occur	and due to the cred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of co	ertifier		29c. Licens	se number		29d. Date signe	d (Month, Day, Year)
	) and I	1		0.C.	M.E.		May 3,	2004
5	30. Name and address of pe	erson who completed cause of	f death (Item 23a) (Type 111	Print) Penn Str	reet, Balt	imore,	Marylan	d 21201
State Registrar	31. Date filed (Month, Day, MAY 1 1	Year) 32. Regis	strar's Signature	Sparker	,			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Lest) **Physician** AMLS 292004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** -UMB ERLAND Dryectional 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 24024917 Days 1 ☐ M 2 ☐ F Months Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar daath with tha Maryland 10d. Inside City Limits 10b. County Department of Haalth and Mantal Hygiana. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10c. City, Tow or Location DATIMORE 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What County? 126 11. Marital Status Was Dacedent of Mispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SHIPYARD SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HUNTER SR. MASSENBURG ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN JOHNSON /DAVGHTER 726 N. LINWOOD AVE. BAUTU, MD 21205 20b. Place of Disposition (Name of cemetery, cremetory or other place) 5-6-of Owines Mills, Maryland GARLISON FOLEST 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Facility VAUGHN C. GREENE FUNERAL HM 21. Signature of Funeral Service Licensee 4905 YORK ROAD BAUTIMORE, MO 21212 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) omas Examiner Be Completed by Physician/Medical Examiner The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Director: After this cartific I in by the funeral diractor, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) WCI Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) TNCIR MORN 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No aftar daath. 6 Could not be determined 3 Suicide within 24 hours aftar da To the Funeral Directo completaly fillad in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10055881 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Western Correctional 31. Date Med Mortin, Pay 200 State Registrar

DHMH 16 Rev 6/95

			For State Registrar	State of M	laryland / Depa <i>Ce</i> a	artment of H			giene Reg. No2 0 0 4	14926
			Decedent's Name (First, Middle, L.)	ast)				2. Date of Dea		3. Time of Death
	Physici /Medio		Ernest E	ig <b>e</b> ne	Hoffmann				7, 2004	9:10 P M
	Examir	er	4a. Facility Name (If not institution, gi	ve street and number	-)		Location of Death		4c. County of Death	
			Casey House  5. Social Security Number 6.	Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	cville  If Under 24 Hrs.	8. Date of Birtl	Montgome	Place (State or Foreign
	Funeral Director		504-48-2668	1 <b>∑</b> M 2□F	58 Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day June 15	, Year) Cout	h Dakota
	σ		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	tion				104 1-14 01 11-14
	f show	ō	Maryland Char	rles	Toc. City, Town of Ec	Waldo	rf			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the A	rect	10e. Street and Number			10f. Zip Code	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10g. Citizen of What Cou	
	3e or	i Di	802 Belfast Rd	•			0602		United Sta	-
	ems 2	Funeral Director	11. Marital Status (Unknown)	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri Black, White,	
36	or its		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ II Yes, Give Year or Dates	No	1 ☐ Yes 2 🌠 No	Specify:	, , ,		nite
21215-0036	72 hours alter death with the Maryland naturel', or items 23e or 28e-f show dical Examiner must be motified at	Completed by	15. Decedent's E			dent's Usual Occupa	ation		16b. Kind of Business/Ir	
215	within 72 ene. than "ne	plet	(Specify only highest gi	rade completed) College (1-4or	(Give	kind of work done on DO NOT use retired	during most of work	ing	Education	,
21	ed wit	Con		5+	Buil	ding Supe				
Maryland	4.2 should be filed within hand Mental Hygiene. 7 Is marked other than "Iraumatic avant, the Mac	Be	17. Father's Name (First, Middle, Las John Gottfrie		ann				<i>Maiden Sumame)</i> Susan Moelt	0 <b>x</b>
N	thould ad Mei mark matic	<sup>L</sup>	19a. Informant's Name/Relationship			ng Address (Street			r, City or Town, State, Zij	
	and 2 sealth ar n 27 ls		Rebecca A. Boswe			Belfast R			20602	3 3330)
Je,	of Hear		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other plac		Date 10,	20c. Location - City or To	own, State
Ë	Pages ment of I ant: If Its ury or o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Chesapeak		riay		Beltsville	e, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "naturel", or liems 23e or 28e-f show any injury or other traumatic avant. The Micdical Examiner must be notified at once.		21. Signature of Fungral Service Inc.	ensee Laure N	200 <b>382</b> 9	app Funer 33 Gist A	ss of Facility cal and Ci ive., Silv	remation ver Spri	Services Ing, MD 20	910
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ő,	be executed siclan and burial-transit	dical Examiner	resulting in death) Last	Due to (or a	s a consequence of):					
8760,	cate be ex physician the burial		•	d						
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	signed to det	by	Part II. Other significant conditions			nderlying cause give	en in Part I.		bacco use contribute to the	he cause of death?
Orc	w requir been sl should	eted	UTI/	a Syria	DWC		-	1 🗆 Y		
Rec	has l ge 2 s	Completed						24a. Was a autops perfori	sy prior to co	psy findings available mpletion of cause of
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0	Jing Ph J. After th tuneral	on: T	27. Manner of Death  1. Natural 5 Pending	28a. Date of In (Month, D	jury 28b. Time of Injury	28c. Injury Work	at c?	28d. Describe h	ow injury occurred	7,00
Sio	Attanding r death. actor: After by the funer	catl	2 Accident investigation 3 Suicide 6 Could not	ha			Yes 2□No	00(1 1 1 10		
Division of	for Attano after death Diractor: in by the	Certification;	4 Homicide determined	286. Place of It	njury - At home, farm, str etc. (Specify)	eet, factory, office		City or Town	treet and Number or Rura n, State)	il Houte Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely tilled in by the funeral		29a. Certifier Certifying P	hysician: To the bes	t of my knowledge, death	occurred at the tim	ne, date and place,	and due to the c	ause(s) and manner as s	tated.
	he Ho in 24 h he Fu pletel)	Medical	(Check only 2 ☐ Medical Exa	miner: On the basis and manner s		vestigation, in my or	pinion, death occurr	red at the time, d	late and place, and due to	the cause(s)
	With To t	Σ	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Month,	Day, Year)
	· X		* walker	MU)			D60582		May 8, 200	)4
	10		30. Name and address of person with Joyson Karakunne				d. Rocks	ville M	D 20852	
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	Registr		MAY 1 1 2004	Deney	PA	souls				

		•	State of Maryland / Department of Healt - State Registrar AMEND TIFM #20b PER FH C831 5/11/04c Frificate of Dea	ath	Reg. N	. <b>L</b> UU4	14927
	Physicia	an	1. Decedent's Name (First, Middle, Last) SANDRA L. HENRY	2. Date of Month	D	ay Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local	tion of Death		2004 c. County of Death	
			Sinai Huspital of Baltimore Baltimor			N/.	4
	Funeral Director			ours Min. 8. Date of (Month	of Birth Day, Year	9. Birth Cou	place (State or Foreign intry)
	land		Usual Residence of Decedent           10a. State         10b. County ,         10c. City, Town or Location				10d. Inside City Limits
	e Mary Se-f eh tiffed	ctor	MD N/A BALTIMORE				1 QYes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or Items 23a or 28e-f ehow any injury or other traumatic event, the Medical Exiting and that the notified at an ance.	Funeral Director	10e. Street and Number 4803 TAMARIND RD APT. 328 10f. Zip Code 212	09	10g. C	itizen of What Cou M.S.A.	
	er deat Items 2	unera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispania If Yes, specify Cuban, Me.	ic Origin? (Specify Yes c exican, Puerto Rican, etc	r No-	14. Race - Ameri Black, White	
≥-0036	ours aft	by	1 SNever Married 2 Married 1 Ses 2 No If Yes, Give Year or Dates:	ecify:		Specify: BL	ACK
₹ <del>7</del>	n 72 ho "natur	letec	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during life, DO NOT use netired)	most of working		Kind of Business/Ir	•
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ORA, Mary	2 shoul and M is mari aumati	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and No.	lumber or Rural Route N	umber, City		
è, Z	1 and Health tem 27 other tr		FERN E. PARSON  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	5/17/04	1	Location - City or T	
SA~,	Pages ment of ent: If i ury or e		*4 Donation 5 Other (Specify)	05 12 2004		resville	, MD
Balt	permit. Departi Import any inj		21. Signation of Funeral Service Licensee 22. Name and Address of FVAUCHN C. CL2	Facility E FUNCE	2AL SE	ERVICES	21229
	- 6		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc shock, or heart failure. List only one cause on each line.	ch as cardiac or respirato	ory arrest,		Approximate Interval Between
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		. A	Registrar		Certificate of Death	Reg. No	
	Physici	an	Decedent's Name (First, Middle, La.	1   1		2. Date of Death	ay Year 3. Time of Death
5	/Medic	al	Lerby L.	Hall	4h Cib. Tourn as Location of Doot	INIAY 7	c. County of Death
es.	Examin	ier	4a. Facility Name (If not institution, give	e street and number)	4b. City, Town, or Location of Deat		A / A
		541	5. Social Security Number 6. S	ex 7. Age (In yrs. last t	pirthday) If Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign
	Funeral Director		,	M 2□F 79	Yrs. Months Days Hours Min.		724 Rountry)
	4.0		Usual Residence of Decedent			rugara	101 Julia grana
	ylan		10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits
	e-f.	cto	Maryland NI	A B	altimore_		1 Yes 2 No
	or 28	Director	10e. Street and Number	11 . 1 .	10f. Zip Code	10g. C	itizen of What Country?
	death with the Maryland ms 23a or 28e-f show	Ta I	2538 Park	Heights le	rrace 21215		USA
	Ø 3	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Amed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	ipecify Yes or No- to Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
2030		by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specity:		Specify: DI
3	E 3	edit	15. Decedent's Ed		a. Decedent's Usual Occupation	16b	Kind of Business/Industry
Ċ	- 30	Completed	(Specify only highest gra	de completed)	(Give kind of work done during most of worlige. DO NOT use retired)	rking	and or Eddinous modelly
717	iene iene	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Machinist	We	Stinghouse
0	be filed withi tal Hygiene. d other ther event, the M	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, Maide	n Sumame)
<u>a</u>		ToE	Eugene t	fall	Mari	VE. Pr	ater
ary	d 2 should th and Mer 7 is marke traumstic		19a. Informant's Name/Relationship (	Type, Print) (SON)	9b. Mailing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
Σ	and 2 salth n 27 I		Mr. Donald	Hall 4	- Liberty Place	"8 Bal	to. Md. 21244
o e	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	cama	of Disposition (Name of / ery, crematory or other place)	Date 20c. L	ocation - City or Town, State
Ē	Pages ment of tent: If it jury or o		*4 □Donation 5 □ Other (Specif	" Gar	rison to rest 3/14	12004 Ou	lings Mills, Md.
gal	Depart Import any in		21. Signature of Funeral Service Cicer	See & Dina	22. Name and Address of Facility	uneral Ha	me
	703 a d		Joseph	of Busis	2222 WiNorth A.	le. Balto.	Md. 2/2/6
				one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a > Chronic	obstructul L	My N'Se	1 de
	/Medical Examiner			Due to (or as a consequence	e of):	)	
		Ē	Sequentially list conditions,	b. Due to (or as a consequence	e of):	)	
	uted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- ENVIONA	medal Lifestal	P FACTO	RS
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Q	death certifica e attending ph ed for use as th	led					
ŏ	th cer rendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 Ectopic pregnancy		23d. Date of delivery
o o	0 0	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month Day Year
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ě	sician: The law certificate has t irector, page 2 s	Completed	100	strue will	7111111111	24a. Was an autopsy perforpred?	24b. Were autopsy findings available prior to completion of cause of death?
_ 			750	VV		1 Yes 2 No	1 Yes 2 No
VII	sicia certi irecto	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Other	ath (Check only one)	C
ō	Phy ar this aral d	-	27. Manner of Death	28a, Date of Injury 28b	. Time of 28c. Injury at	lome 5 Residence 28d. Describe how inju	
o	nding ith. :: Afte	atloi	1/□Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury Work?  M 1 Yes 2 No		
DIVISION	Atte	ific	3 Suicide 6 Could not b	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street as City or Town, Stat.	nd Number or Rural Route Number,
5	s afte	Certification;	4 Differences	building, etc. (Opecny)		Only of Form, Class	θ)
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best of my knowled	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred.	e, and due to the cause(s	s) and manner as stated.
	the H nin 24 the F nplete	Medical	one)	and manner stated.			
	To To	~	29b. Signature and title of certifier	0.	29c. License number	29d. Da	ate signed (Month, Day, Year)
•	X		Lullam	prens	N) PUULTS		7/10/04
	10		30. Name and address of person who	completed sause of death (Item 23a	(Type, Print)	no Bas	2512 CM I
	Sta	ite	31 Date filed (Month, Day Year)	32. Registrar's Signature	1	1 11/10	)
	Registr		MIAI I I ZUU4	Current O	BOOK KAL		

		for Amend Item: State Registrar  1. Decedent's Name (First, Middle	29d per br. 484	,03711 	7646B Ce	artment of rtificate of	Health Death	1		Reg. No.		) L <sub>3</sub>   L <sub>4</sub>	9 2 of Death
Physici /Medi	cal	Ruth Purdy	Bernhard	Нор	kins	4b. City, Town,	or Location		Month April	6 Day	2004 County of D	9:20	
Examir Funeral	ner	4a. Facility Name (If not institution, Genesis Eldero  5. Social Security Number	are - Spa Cr	(In yrs. la	ast birthday)	Annapo If Under 1 Yea Months Days	lis	r 24 Hrs. 8	B. Date of Bir (Month, Da	th	Anne A	runde1  Birthplace (State Country)	or Foreign
Director		214-05-1007 Usuel Residence of Decedent	1 W 2011	91	Yrs.			C	ct. 9,	191	12 M	aryland	
e Marylar ta-f show	ctor	MD Anne A	rundel	_	napol							10d. Inside C	ity Limits
or 2	Dire	10e. Street and Number			" -	10f. Zip Code					zen of What	Country?	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show aurmatic event, the Mydical Examinar marke notitied at	by Funeral Director	2016 Governor  11. Marital Status  1 Never Married 2 Marria 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces?	ver in U.S	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Or ban, Mexica		ify Yes or No ican, etc.)			merican Indian, thite, etc. White	
thin 72 hou e. an "naturi Mioloil E	Completed	15. Decedent (Specity only highes Elementary/Secondary (0-12)	s Education t grade completed)  College (1-4or 5-	+)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during mos	st of working	9	16b. Ki	nd of Busine	ss/Industry	
ed wil	Con	12		1	Home	maker	1				Home		
ed la b	Be	17. Father's Name (First, Middle, I							(First, Middle,		,		
should be ind Mental I marked o	2	John Thomas Pu			10h M-10	ng Address (Stree			Evele			- 7:- C-d-1	
1 and Health em 27		Joyce Evans (S	Sister)	20b. Pl	2016	Gov. The sition (Name of matory or other pi	omas E		Way,	#1,	Annap		214
Pages nent of ant: If It any or o		1 ☐ Burial 2 【A Cremation • 4 ☐ Donation 5 ☐ Other (S <sub>i</sub>				ematory		4/8/2	.004	Balt	imore	, MD	
permit. Pages Department of Important: If II any injury or once.		21. Signature of Funeral Service	ignlee June		22	Name and Add Hardest 12 Ridg	y Fune	eral H	lome, F	.A.		72	
Death certificate be executed /Medical Examiner transit to see as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, Learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a d. Due to (or as a d.	e. a consequ	ence of):	Mun ev	\	e men		11031,		Approxima interval Be Onset and	tween
that the death certific led by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	□Ectopic pregnan □ Other (specify)	су			2	23d. Date of Month	,	Year
quires that n signed b uld be deta	by	Part II. Other significant condition	ns contributing to death bu	it not resu	liting in the u	inderlying cause g	oven in Part	1.	23e. Did to			e to the cause of o	
yaician: The law requires that the is certificate has been signed by the director, page 2 should be detached to the control of	Completed								24a. Was autop perfo 1  Yes		24b. Were prior death		available ause of
	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 Solo  27. Manner of Death  1 Detatural 5 Pendin 2 Accident investig		y T	ER/Outpatier 28b. Time o Injury	of 28c. Inj	ther:	ursing Home	Check only of a State of the Control	dence 6		(pecify)	
	Certification:	3 Suicide 6 Could r 4 Homicide determ	28e. Place of Inju building, etc	ry - At ho	me, farm, st	reet, factory, office	9	28	3f. Location (S City or Tox			Rural Route Nun	nber,
To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	edical (	29a. Certifier 1 Check only one) 1 Medical	g Physicien: To the best of Exeminer: On the basis of and manner sta	examinat	wledge, deat ion and/or in	th occurred at the evestigation, in my	time, date as opinion, dea	nd place, an ath occurred	nd due to the d at the time,	cause(s) date and	and manner place, and o	as stated. due to the cause(s	5)
To the To the complet	Me	29b. Signature and title of certifier					nse number			29d. Dat	e signed (Mo	onth, Day, Year)	/2MV
		30. Name and address of person	ho completed cause of de	eath (Item	23a) (Type.	Print)	1320	36		21	110	84 04/01	, 2004
		31. Date filed (Month, Day, Year)	or tule )/	081	JIDM	ah Dri	ve C	Lister	MO	210	019		
St: Regist	ate rar	MΔY 1 1 2004	Land	4	1	20. 4.1							

Gary Johnson 04-3081 AKG

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Johnson		Flease I	Otata of Mandand / Day	ndelible ink. Ensure A	Mantal Husia	e Legible.
81	_	1 - For Unpend Item #23a, Registrar	zjate or Maryland (1) e zjate	partment of Health and I 2504 tas ertificate of Death		
Physicia /Medic	al .	1. Decedent's Name (First, Middle, Last)	NON	4. Ch. Taura and position of Control	May 6,	Day Year 3. Time of Death 5:31 PM
Examin	er	4a. Facility Name (If not institution, give st Union Memorial Hos		4b. City, Town, or Location of Death Baltimore		4c. County of Death
Funeral Director		5. Social Security Number 5 18. Sex 12	M 2□ F 7. Age fin yrs. last birthda		8. Date of Birth	ar) 3 9. Birthplace (State of Foreign
the Maryland 28a-f show	or	Usual Residence of Decedent  10a, state  10b. County	10c Gity Town or	Location		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
death with the Maryland ms 23e or 28a-f show rmust be notified at	Director	10e. Street and Number	AVE.	10f. Zip Code 2/1/2/1	10g.	Citizen of What Country?
after or Ite	/ Funeral	1 Z Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces? 1	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White Jetc. Specify:
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If liem 27 is marked other then "naturel", or Ite eny injury or other treumatic event, the Medical Examplance.	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ (Specify only highest grade	Year or Dates:  ation 16a. Decompleted) (Gi	cedent's Usual Occupation We kind of work flone during most of wor I DO NOT use retired)	king 165	Kind of Business/Industry
iled withi Tygiene. Iher then nt, iik k		Elementary Decordary (0-12)	90/14 (1-4or 5+) SA	EMAN 18 Mother's Nan	ne First, Middle Maig	SUSTEINS  (en dumame)
iould be f Mental H narked of natic eve	To Be	EDGAR JOHNBOI	U	MARY	H. JOHNE	ON
and 2 sh ealth and n 27 is rr		19al Informant's Name-Helationship (1/2)	MOLHOR) 50%	ailing Address (Street and Monther of Ru	GEELSON	N. CAROLINA
Pages 1 nent of H ant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	post n ame o rem ry he lace)	Date 200	ALMOCE NO
permit. Departitimport		21. Signature of Furferal Service Ucehalo	falmou	22. Name and Address of Figure 10	VE. BAH	60.M. 2202
Physician /Medical		23a. Part   Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not do cause on each line.  Cocaine Intoxication  Due to (or as a consequence of):	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
Examiner	Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
te be ysicia e bur		if any, leading to immediate cause. Enter Underlying Cause (Disease of the Arthur that initiated events resulting in death) Last				
The law requires that the death certificate late has been signed by the attending physicage 2 should be detached for use as the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
w requires that the description is been signed by the should be detached		Part II. Dther significant conditions cont	ributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 \( \sum \) No \( 3 \sum \) Probably 4 \( \frac{1}{2} \sum \) Unknown
					24a. Was an autopsy performed' 1 XYes 2	
rsicien: Th	o Be	25. Was case referred to medical examiner?  1 ∑ Yes 2 □ No	ospitat: 1 ☐ Inpatient ②CER/Outpat	Other	th (Check only one) ome 5 Residence	6 □Other (Specify)
Attending Physicien: or death. ector: After this certific by the funeral director.	ıtlon: T	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury Found th, Day Year) 5-6-04  28b. Time Found 5-000	of 28c. Injury at	28d. Describe how in	
after deta after dea Director	Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At home, farm, building, etc. (Specify)  Found on school steps	and Number of Rural Route Number ate) 2920 Barclay Street		
To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C		cian: To the best of my knowledge, de	eath occurred at the time, date and place investigation, in my opinion, death occu		(s) and manner as stated.
To the within To the comple	Me	29b. Signature and title of certifier	1.0	29c. License number	29d. I	Date signed (Month, Day, Year)
		Theodre M	1. Kans	O.C.M.E.	May	y 7, 2004
		30. Name and address of person who cor	npleted cause of death (Item 23a) (Typ	,	D. 11.	
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	111 Penn Street,	Baltimore,	Maryland 21201

S Registrar

MAY 1 1 2004

ORIGINAL

Physici	an_	Decedent's Name (First, Middle, I	.ast)				2. Date of Deat	h Day	04 14 9 Year 3. Time of Dea
/Medi		Kenneth			Jones		MAY 2,		1:39 I
Examir	ner	4a. Facility Name (If not institution, g JOHNS HOPKINS H		7)		r Location of Death ORE CITY	n	4c. County o	f Death
Funeral Director		225-02-0742	Sex 7. A 1□XM 2□F	ge (In yrs. last birthda) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7–10–6	Year)	Birthplace (State or For Country)     Va
M D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Lir
death with the Maryland ms 23a or 28e-f show	to	Md. NA		Baltimo	ce				1 🛣 Yes 2 🗆
or 28e	irec	10e. Street and Number			10f. Zip Code		10	0g. Citizen of Wi	nat Country?
23a	ral	1616 Cliftview			212	213		USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "neturel; or Items 23a or 28e-f show any injury or other treumatic event, Ite Marie a Examination is used by notified at once.	by Funeral Director	11. Marital Status  1 → Never Married 2 → Married 3 → Widowed 4 → Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Year or Dates	? ]No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√ No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	Black	- American Indian, , White, etc. Black
	Completed	(Specify only highest grade completed) (Give			e kind of work done	dent's Usual Occupation 16 kind of work done during most of working DO NOT use retired)			b. Kind of Business/Industry
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ed off	Be	17. Father's Name (First, Middle, La	st)				ne (First, Middle, M	Maiden Sumame	_
marke matic	2	UNKN 19a. Informant's Name/Relationship	(Type, Print)	19h Mai	ling Address (Street	Hannah and Number or Ru		City or Town S	Jones
27 is			Aunt		6 Cliftvie				21213
item item otha		Shirley Jones 20a. Method of Disposition		20b. Place of Disp					ity or Town, State
permit. Page Department o Importent: If any injury or once.		1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Control C		A .	rmel Cem.		.3-04	Dundalk	, Md.
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4 hours after death. Funerel Director: After this certificate has been signed by the attending r ely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pending investigat  2  Accident 3 Suicide 4 Homicide 6 Could not determine	Due to (or a  c.  Due to (or a  d.  23c. If yes, outcom 1	e of pregnancy 2	Other (specify)  underlying cause give  ent 3 DOA Other  of 28c. Injun  word  treet, factory, office	en in Part I.  26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 ▼ No	24a. Was ar autops) perform 12 Yes 2 th (Check only one ome 5   Reside) 28d. Describe hor unknown 28f. Location (Str. City or Town, 1616 Clift) and due to the ca	Monting accourse contribution accourse contribution accourse contribution accourse contribution accourse contribution accourse contribution accourse contribution accourse contribution accourse contribution accourse contribution accourse contribution accourse contribution account accoun	th Day Year  The
r death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or a  c. Due to (or a  d. 23c. If yes, outcom 1	e of pregnancy 2	Other (specify)  underlying cause give  ent 3 DOA  of 28c. Injun  worl  treet, factory, office  th occurred at the tim nvestigation, in my of	en in Part I.  26. Place of Dea er: 4 □ Nursing He y at k? Yes 2 ▼ No ne, date and place, pinion, death occur	24a. Was ar autops) perform 1 Yes 2 th (Check only one 5 Reside) 28d. Describe hor unknown 28f. Location (Str. City or Town, 1616 CLiff), and due to the carred at the time, da	Montinacco use contribution of the contributio	th Day Year  The Day Year  The Day Year  The Day Year  The Day Year  The Day Year  The Day Year  The Day Year  The Day Year  The Day Year  The Day Year  The Day Year  The Day Year  The Day Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 520 AM Jandla 2004 Constance May /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner HMME John Age (In yrs. last birthday) (State or Foreign 5. Social Security Number **Funeral** Min. Months Days 1 □ M 2 🗙 F Hours MD 217-16-4488 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, Sfate 10b. County Itam 27 is marked other than "natural", or Items 23a or 28a-1 shov other traumatic event, the Medical Examinal must be collided at 1 ☐ Yes 21 No Pasadena Maryland Anne Arundel Direct 10g. Citizen of Whaf Country? 10e. Street and Number 10f. Zip Code USA 21122 420 Virginia Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify Specify þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Bookeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bonkowski Cecelia Frank Schirm ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stone Drive, Pasadena, MD 21122 46 Marilyn Mab<u>e</u> (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) May 12 20c. Location - City or Town, Sfete 20a. Method of Disposition Department of Important: If it any injury or o 1 Burial 2 Tremation 3 Removal from State 2004 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 21. Signature of Farreral Service Dicensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart citizen. List only one cause of each line. Onset and Death Immediate Cause (Final WEEK INNE. OF PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): FAILURE OF ONE MONT CONGESTIVE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): VF TEN EMPHYSEMA YEARS that initiated events resulting in death) Last Due to (or as a consequence of) FIRTHER

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

28a-f show

nd Mentat Hygiene. marked other than

and Mental

attending physician and for use as the burial-transit

Physician/Medical þ Completed Be Certification: To after death.
Director: Af filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

After

within 24 hours a To the Funeral L

Division of Vital Records, P.

.O. Box 68760

IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Dunknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

CORONMEY

3 Ectopic pregnancy 5 Other (specify)

MRTERY

MILEASE

23d. Date of delivery Month Day

Year

4 FIARS

23e. Did tobacco use contribute to the cause of death? TVes 2 No 3 Probably 4 Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? autopsy 20 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one)

08

2004

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Dafe of Injury (Month, Day Year) 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred Injun 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)

💓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe

29b. Signature and title of certifier MD D0055973 Icassalun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

MB 20904 WAG SILVER SPRING Desse 11500 SUTHERLAND HILL ZeICILE 31. Date filed (Month, Day, Year)

State Registrar

Medical

32. Registrar's Signafure 2004 a comment

		State of Maryland / Department of Health and 1- state amend 11 & 19a per info.G843 Certificate of Death		
Physicia /Medic	al	Name (First, Middle, Last)  RICHARD T. JENKINS, JR.  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of December 1.	2. Date of De. Month 05 08	Day Year
Examin Funeral Director	C	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	rs. 8. Date of Birt	Anne Arundel
	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Pasadena	11/23	10d. Inside City Lim 1 □ Yes 2
ural', or items 23a or 28a-f show al Examiner must be nutified at	by Funeral Director	10e. Street and Number  755 Duvall Highway  11. Marital Status 1 □ Never Married 3 ◯ Widowed 4 □ Divorced  10f. Zip Code 21122  12. Was Decedent Ever in U.S. Amped Forces? 1 ☑ Yes 2 □ No 1951 − If Yes, Sieve 1 □ Yes or Dates: 1953 1 □ Yes 2 ☑ No Specify:		10g. Citizen of What Country?  U.S.A.  14. Rece - American Indian, Black, White, etc.  Specify: White
jene. r than "na the Medic	Completed b	15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of wild iffe. DO NOT use retired)   12   Stenotypist	vorking	16b. Kind of Business/Industry U.S.Government
d oth	To Be C		lame (First, Middle,  C. Schne  Bural Boute Number	eider
of Health and Mer f item 27 is marke r other traumatic		Annette A. Bell, friend Annette Jenkins, Wife  20a. Method of Disposition  1 Surial 2 Cremation 3 Removal from State		
Department of Important: If it any injury or o once.		`4 Donation 5 Other (Specify) Our Lady of Fields 05	J.Gonc	e Funeral Home, P
hysician Medical xaminer	Examiner	23a. Part 1. Eryer the disease, or complications that caused the death. Do not enter the mode of dying, such as carding shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	iac or respiratory ar Eleve protery	rest, Approximate Interval Between Onset and Death Years
ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Ex	Due to (or as a consequence of):  d		23d. Date of delivery Month Day Year
been signed should be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	10)	obacco use contribute to the cause of death
	e Completed	25. Was case referred to medical 26. Place of D	24a. Was autop perio 1 Yes	prior to completion of cause death?  2 No 1 Yes 2 No
After this	To B	examiner?  1	Home 5 Resid	dence 6 Other (Specify) now injury occurred
Funeral Director: 1 tely filled in by the f	al Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	City or Tow	cause(s) and manner as stated.
within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.  29b. Signature and title of certifier 29c. License number 7 (9512)	curred at the time,	date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
()		30. Name a d address of person who completed cause of death (Item 23a) (Type, Print)  SANG C. Do H. M.D., 1600 Crain High way	Calt	6 Flon Burnle W

ORIGINAL

State Registrar CHARL MEHTA

29b. Signature and title of certifier

Chalita MI)

32. Registrar's Sonature

MD

29c. License number

D34974

29d. Date signed (Month, Day, Year)

May 4th

Street, Buifimore MD2/1230

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 200 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 6:20 PM KRAUSE LLFRIEDE 2004 MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SILUER SPRING If Under 1 Year | If Under 24 Hrs. TARK PLACE MAPLEWOOD MONTGOMERY 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min 1 ☐ M 2 🛱 F 92 Yrs. Director 372-16-6553 3Ó, 1911 Indiana Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Heatilt and Mental Hygiene ansit: If item 27 is marked other then "neturel; or Items 23e or 28e-f show usy or other the unsitie event, I'm Medical Engine may be notified at ury or other the unsitie event, I'm Medical Engine may lear of lifes of a 1 ☐ Yes 2X No Completed by Funeral Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 Old Georgetown Pike 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎹 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Economist Federal Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edmund Α. Η. Kayser Theodora Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Importent: If item 27 is eny injury or other treu QRG. Christine P. McGuire / Trustee 6966 Robb St.; Arvada, CO 80004 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State May 11, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2004 Beltsville, MD <sup>22</sup>. Name and Address of Eacility Rapp Funeral and Cremation Services Rapp Funeral and Cremation 933 Gist Ave., Silver Sprir Shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD 20910 RESPIRATOR Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** NEUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner physician and s the burial-transit the Hospitel or Attending Physicien: The law requires that the death certificate be executed ATERAL resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 🗆 Yes Division of Vital 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funerel Director:
completely filled in by the 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State
Registrar

DHMH 17 Rev 1/2001

AAY 1 1 2004

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

VEMURY MD

32. Registrar's Signature

Serve & Sport

9801

MN 20902

6 EORGIA

			1 - For State Registrar	State of M	aryland		artment of H		nd Mental Hy	giene Reg. No. 2	004	14936
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last Robert Atlee	Kemp					2. Date of De Month May 8	Day 2004	Year	3. Time of Death 9:54 a
	Examin	er	4a. Facility Name (If not institution, give  1017 South Carrol  5. Social Security Number 6. Se	l Street	e (In yrs. la	et hirthday)	4b. City, Town, or Hamps If Under 1 Year	stead			Carro	11
o <sub>.</sub>	Funeral Director			M 2□F	83	Yrs.	Months Days	Hours	Min. 8. Date of Bin (Month, Da Apr 17	, 1921	Mary	place (State or Foreign ntry) Land
	e Marylan 8a-f ehow	ector	Maryland Carroll		10c. City,	Town or Lo		Marylar	nd			10d. Inside City Limits 1 ☐ Yes 2反 No
	ath with the 23 a or 2 trust be n	Funeral Director	10e. Street and Number 1017 South Carrol					21074		10g. Citizen o	USA	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If lem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be motified anongoe.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:		81	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2√2 No	ispanic Origir in, Mexican, I Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Spec	lace - Ameri lack, White, cify:	
0-6171	within 72 ho ane. than "natur ne Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	cation e <i>completed)</i> College (1-4or :		(Give life. [	lent's Usual Occupi kind of work done of DO NOT use retired Ventory (	during most o		16b. Kind of	Business/In	dustry
alla z	uld be filed the filed the filed the filed the filed other fice event, the file event, the filed	To Be Co	17. Father's Name (First, Middle, Last) Ralph O. Kemp				ventery	18. Mother's	Name (First, Middle, nie A. Arma	Maiden Sum		
, Ivial y	and 2 shou ealth and N m 27 is man		19a. Informant's Name/Relationship (7) Oden Kemp, brothe						or Rural Route Numbe Hampstead			Code)
	Pages 1 and the ment of He ant: If item ury or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cen	netery, crem	sition (Name of natory or other place ek Cemete		Date 5/12/2004	20c. Location	n - City or To Vindso	
Dail	permit. Departr Imports any inji		21. Signature of Funeral Service Licens	MO	723 Cen	0	Name and Addres		Eline Fi St, Hamps		ar may be because their	74
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only old immediate Cause (Final disease or condition resulting in death)	cations that caused ne cause on each line.  Due to (or as	VD	)	er the mode of dying	g, such as ca	rdiac or respiratory ar	rest,	V	Approximate Interval Between Onset and Death M. M. W. L. C.
,00,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United Section 1997, that initiated events resulting in death) Last	Due to (or as								
.O. DOY O	ath cerni attending for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	léath 3□	Ectopic pregnancy Other (specify)				Date of delive	ory Day Year
1 (cp.	w requires that the or been signed by the should be detached	by	Part II. Other significant conditions con	ntributing to death b	ut not resulti	ing in the un	derlying cause give	en in Part I.		bacco use co es 2□No	ntribute to th	ne cause of death?
	cate has been page 2 should	Completed							24a. Was a autop: perfor 1 \( \triangle \trian	sy /	prior to cor death?	psy findings available impletion of cause of
	his certif	To Be	1 93 2 10	lospital: 1 🗌 Inpatie		P/Outpatient		er: 4 🗆 Nursi	Death (Check only or ng Home 5 Resid		ther (Specify	<i>'</i> )
	to the negation of well and the form of the conflicted has the death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	27. Manne of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Inju (Month, Day		8b. Time of Injury		at i? ∕es 2 □ No				
	prist of A ours after o eral Direc filled in by	al Certif	4 Homicide determined	28e. Place of Injubulding, etc.	c. (Specify)				28f. Location (S City or Tow	n, State)		
	the Fun the Fun npletely	Medica	one)	ner: On the basis of and manner sta	examination	n and/or inv	estigation, in my op	oinion, death	place, and due to the coccurred at the time, d	ause(s) and n late and place	nanner as st , and due to	ated. the cause(s)
	2 tg o 5	*	29b. Signature and title of cartifier				29c. License	1921	2	19d. Date sign ∧ay (U	ed (Month, 1	Day, Year)
	6x1		Herbert 1. Henc	mpleted cause of d	eath (Item 2	3a) (Type, F	3 Manch	lester 1	Red Manch	N=5/4/	MP	2118
	Star Registra		31. Date filed (Month, Day, Year) MAY 1 1 20	32. Segistra	ar's Signatur	e de	and!					

			for State Registrar	State of Maryla	and / De <i>C</i>	partment of Hea ertificate of De	alth and Mer eath	ntal Hygie Reg		14937
	Physici /Medio		1. Decedent's Name (First, Middle, Las KAREN KEARI					Date of Death Month	Day Year 8 2004	3. Time of Death  5 26A M
3	Examir Funeral Director		4a. Facility Name (If not institution, give 5. Social Security Number 6. Sec. 218-64-0418	Ballimor	ers. last birthda		cation of Death	Date of Birth (Month, Day, Y. 0 - 1 6 - 5	4c. County of Death N / A	place (State or Foreign
/	D	or	Usual Residence of Decedent  10a. State 10b. County  MD -			'IMORE		0-10-3		RYLAND  Od. Inside City Limits  1 □ ¥es 2 □ No
2	with the e or 28a Le poti	Funeral Director	N/A 10e. Street and Number 5738 JOHNQUIL	AVE.		10f. Zip Code 21215		10g	. Citizen of What Cour	
036	72 hours after death with the Marylan natural', or items 23e or 28a-f show iteal Evantine must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 U.S. 1	3. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 ☒No Sp	nic Origin? (Specify Mexican, Puerto Rica pecify:	Yes or No- an, etc.)	14. Race - Am <i>e</i> nd Black, White, Specify: BLA	etc.
21215-0036	"natur	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5+) 4	(Gi	cedent's Usual Occupation ve kind of work done during by DO NOT use retired) ISPATCHER	n ng most of working		b. Kind of Business/In	
Maryland	be file tal Hy d othe event,	To Be C	17. Father's Name (First, Middle, Last)  Joseph J			18.	Mother's Name (Fi	rst, Middle, Mai y Brow		
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (7.  JAMES KEARNEY  20a. Method of Disposition	HUSBAND	57	illing Address (Street and I 38 JOHNQUI:		BALTO.		5
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 Surial 2 Cremation 3 1 4 Donation 5 Other (Specify 21. Signature of Fundral Service Licens	Removal from State	cemetery, c	rematory or other place) ION CEM.  22. Name and Address of 4600 Liber	05-13-	-04 1	MARYLAND eral Hom	e
	Medical Examiner	I Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listers underlying that initiated events resulting in death) Last	ilications that caused the deline cause on each line.  a	eath. Do not a sequence of):					Approximate Interval Between Onset and Death
.O. Box 68760	The law requires that the death certificate be to has been signed by the attending physicis age 2 should be detached for use as the bu	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of prec 1□Live birth 2□F. 4□Pregnant at time o 9□Unknown	etal death	B □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	rry Day Year
ords, P	w requires that been signed b should be deta	by P	Part II. Other significant conditions co	ntributing to death but not r	esulting in the	underlying cause given in	Part I.	23e. Did tobac	co use contribute to th	e cause of death? ably 4 □Unknown
of Vital Records,	(0 77	e Completed	25. Was case referred to medical					24a. Was an autopsy performed 1 Yes 2 1	prior to cor death?	osy findings available inpletion of cause of 2 No
Division of Vit	ng Phys tter this ineral dii	ertification; To Be	examiner? 1	Hospital: 1 Impatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpati 28b. Time Injury	ent 3 DOA Cther: 4 of 28c, Injury at	28d.		e 6 □Other (Specify njury occurred	")
Divis	To the Hospitel or Attendi within 24 hours atter death. To the Funeral Director: A completely filled in by the fu	O	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	cify)			City or Town, S.		
	o the Hos ithin 24 hc o the Fun ompletely t	Medical	(Check only one)  29b. Signature and the of certifier	sician: To the best of my kiner: On the basis of exami and manner stated.	ination and/or	ath occurred at the time, dainvestigation, in my opinior  29c. License num	n, death occurred a	t the time, date	e(s) and manner as strand place, and due to  Date signed (Month, L	the cause(s)
	P S P O	1	30. Name and address of person who c	Sung MD	em 23a).(Tvn	RES-C	00	M		004
	Sta	te	IK Suna M! 31. Date filed (Month, Day, (Sa))	Singi H	ospita matur	of Baltin	4700			
DH	Registr MH 17 Rev 1/20	1 4	MAY 1 1 20	104	St. A	franks				

ORIGINAL

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	DAP		For Stete	State of Ma	aryland / Depa			-	_	2001	11000
			Registrar		Cei	rtificate of D	eatn		Reg. No.	1004	14938
	Physici	an	1. Decedent's Name (First, Middle, La MONICA KCY:	*				2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Town, or L	postion of Dooth	MAY		2004 County of Death	11:11a "
4	Examin	er								•	
	Francis		REAR OF 27 THORNH 5. Social Security Number 6.5		(In yrs. last birthday)	WOODLAW If Under 1 Year	IN If Under 24 Hrs.	8. Date of Bir	th	BALT IMOI 9. Birthp	lace (State or Foreign
	Funeral Director			1□M 2 <b>5</b> 2′F	4 Yrs.	Months Days	Hours Min.	(Month, Da	y, Yeer)	Coun	MD MD
	D		Usual Residence of Decedent					00)			
	show	_	10a. State 10b. County	MORE	10c. City, Town or Lo					11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f s	cto	1011	IVIURU	BALI	IMORE					
	vith th	Funeral Director	10e. Street and Number	0-110-		10f. Zip Code			10g. Citiz	en of What Coun	-
	s 23s	ral	27 THORNHURST			21.	201			U.S.A	
	item	une	11. Marital Status  1 ☐ Never Married 2 ★ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑		Was Decedent of Hisp If Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	-   ''	Black, White,	
36	rs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 No	Specify:			Specify: BL	4CK
5-0036	within 72 hours after death with the Maryland one. then "natural", or items 23a or 28a-f show then "natical Ezart activitied at		15. Decedent's E	ducation	16a. Dece	dent's Usual Occupati	on		16b. Kin	d of Business/Inc	dustry
215	hin 7.	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	+) life.	kind of work done dui DO NOT use retired)		ng			0 . 0 =
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nd	at Hy at oth	Be (	17. Father's Name (First, Middle, Las			1	8. Mother's Name				
yla	Ment Ment arke	L <sub>O</sub>	ARTHUR E.K				MARG				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, I'm Madical Ezam activities to inclined at		19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street and					2.170
_	1 and Health em 27 ther tr		MARGO KEYS  20a. Method of Disposition		20b. Place of Dispo	SOUTHE		oate DKI		ation - City or To	
Baltimore,	0 0 = =		1 Burial 2 □ Cremation 3 [		cemetery, crei	natory or other place)		1 (			
Ħ	permit. Pag Department Important: I any injury c		' 4 □ Donation 5 □ Other (Special 21. Signature) of Funer (I Section Lice	~~	ARBUT					MORE	5 TIOLD
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	)	كِ ا	Name and Address AUCHN C. E	-Reene Fr	UNGRAL.	serv	ces	
			23a. Part1. Enter the disease, or con	onlications that caused		151 BALTIMI				HTIMORE	Approximate
			shock, or heart fature. List only Immediate Cause (Final	one cause on each lin	18.				,		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a ASDY	MXIA						
1	Examiner			Due to (or as	a consequence of):						
	¢.	er	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence of):	-					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
60,	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):						
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687	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	15.55****								
Box	th ce tendii r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		Ectopic pregnancy			23	3d. Date of delive Month	ry Day Year
		sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	time of death 5	Other (specify)		-		WORK	Day Toal
P.0	ac ac	Phy	9 Unknown Part II. Other significant conditions	contributing to doath h	it not reculting in the u	ndorhving oguso gavon	in Part I	23a Did t	obacco us	e contribute to th	e cause of death?
JS,	ires tha signed d be del	Completed by	Fait II. Other arginicant conditions	contributing to death be	at not resulting in the d	ilderlying cause given	illi aiti.	1 🗆 1		6	
Record	w requir been si should	etec		· · · · · · · · · · · · · · · · · · ·						-	
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aF	icien: The certificate ha							1 Yes	2□No	1 Yes	2□ No
of Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death			_	A.E. COTNE
of	Phys r this ral di	. To	t Yes 2 No 27. Manner of Death	1 ☐ Inpatie		IL 3 DOA	4   Nursing Hor	ne 5 ☐ Resid 28d. Describe I			AT SCENE
on	Attending I r death. ector: After by the funer	tlon	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	Month, Day	Year) Found	28c. Injury a Work? LAM 1 □ Ye	- LL -	subject			iated
Division	l or Attendi after death. Director: A In by the fu	fica	3 ☐ Suicide 6 ☐ Could not I	28e. Place of Inju	ry - At home, farm, str		/	28f. Location (S	Street and	Number or Rura	l Route Number,
D	al or A after I Direction by	Certification:	4 Homicide determined	building, etc	in Woods		6	City or Tov		nomhust	C+ Woodlaw
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifying P	hysician: To the best	of my knowledge, deat	h occurred at the time.	, date and place, a	and due to the	cause(s) a	ind manner as st	ated.
	he Ho n 24 t ne Fu sletels	edical	(Check only Medical Exa	miner: On the basis of and manner sta		vestigation, in my opin	nion, death occurre	ed at the time,	date and p	lace, and due to	the cause(s)
	To the Ho within 24 h	M	29b. Signature and title of certifier	,		29c. License r	number		29d. Date	signed (Month, L	Day, Year)

State

7 Moder W. U. January 1990.

30. Name and address of person who completed Juse of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 MENDS NEW KM 31. Date filed (Month, Day, Year) WINY 1 1 2004

32. Registrar's Signature

8,

MAY

2004

Registrar DHMH 17 Rev 1/2001 29c. License number OCME

MARY J.LAMB 04-03040 RKD

unpend item#23a-b,Part II,27,PER ME,C833,7/8/04eg
Please Type or Print in Black Indelible link. Ensure All Copies Are Legible.

	1	For State Registrar	State of Maryland /	Depa <i>Cei</i>	artment of H <i>tificate of L</i>	ealth and I Death	Mental Hygie		14939
Physician		1. Decedent's Name (First, Middle, Las:					2. Date of Death Month MAY	Day Yeer 4,2004	3. Time of Death 5:00P. M
/Medical Examiner		ta. Fecility Name (If not institution, give UNION HOSPITAL			4b. City, Town, or ELKTON	Location of Death		4c. County of Death	
Funeral Director	3	5. Social Security Number 6. Se  2/4-96-46/0  Usual Residence of Decedent	X 7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth Cou	place (State or Foreign intry) FL,
death with the Maryland ms 23e or 28e-f show rmust be notified at neral Director		10a. State 10b. County	FORD 10c. City, To	wn or Lo	CO NOWIN		10g	. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
<u>ĕ</u> ₽ ₹ ĕ		7 Wood Side 11. Marital Status 11 Hever Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give		Was Decedent of His f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
Z1Z15-UU36 ed within 72 hours at ygiene. her than "natural", or it, ithe Medical Exam t, Tompleted by F	חשובונה בא	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	Year or Dates:	a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired	ation furing most of wor	king	b. Kind of Business/li	
ire, Maryland 21215-0-0 s 1 and 2 should be filed within 72 hc ( Health and Mental Hygiene, item 27 is marked outher than "naturalice event, the Medical To Be Completed		17. Father's Name (First, Middle, Last)	NIA	•	rever	18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)	9
y, Maryland and 2 should be file eath and Mental Hy m 27 is marked oth ner traumatic even To Be (		19a. Informant's Name/Relationship (7 Judy Lamb		7	wood sid	e Can	ni is Cir	City or Town, State, Z.	110
timo t. Page rtment o rtant: If njury or		20a. Method of Disposition  1 Burial 2 Commation 3   4 Denation 5 Other (Specify  21. Ignature Funeral Service Licen.	Removal from State  BAYL  See	of Disposition of Dis	sition (Name of natory or other place C.C.C.M.T.C.). Name and Address	BRy 5/	10/04 1	341to. M	Approximate
Dermi Depa Impo Impo any it		23a. Parh. Enter the disease, or company spock, or heart failure. List only of	lications that caused the death. Do	not en	HAZTLEY M 5-27 h s.r.f. er the mode of dying	g, such as cardiac	13.0 Hz. M	21734	Approximate Interval Between Onset and Death
be executed be executed ician and maintenant buriat-transit and Examiner al Examiner	Type	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsis  Due to (or as a consequence  Pyelonephritis  Due to (or as a consequence  c.  Due to (or as a consequence	of):					
. BOX 68 / 60 death certificate be attending physicial of for use as the bursicial of the b	200	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☎ Unknown	d		Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
		Part II. Other significant conditions on Narcotic and Cocair		in the u	nderlying cause give	an in Part I.		cco use contribute to	the cause of death?
The law ate has to page 2 s	and inco						24a. Was an autopsy performe 1 X-Yes 2 C	d? prior to c	opsy findings available ompletion of cause of 2 \square No
VISION OF VITAL F Attending Physician: Th r death. sector: After this certificate by the funeral director, page fillcation: TO Be CO	2	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	(Month, Day Year)	utpatie Time o Injury	f 28c. Injun Worl	er: 4 Nursing H	ath (Check only one) lome 5 Residence 28d. Describe how	ce 6 Other (Specinjury occurred	ify)
= 2227 t		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)			na data and place	City or Town,		
the the	Medica		iner: On the basis of examination a and manner stated.			pinion, death occu	irred at the time, date		to the cause(s)
To To Con		JOSSES ST. 30. Name and address of per in who	1	) (Туре,	Print)	O.C.M.E.	MA	7,2004	
State Registrar	100	31. Date filed (Month, Day, Year)  MAY 1 1 2004	1 Meth M.D. 32. Registrar's Signature	bou		street,	<u> Baltimore</u>	, Maryland	71201

			1 - For State Registrar AMEND IIFM #24	State of Marylan	•					giene, Reg. No!	2005	, 11,	940
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea	ath	Year	. 1	of Death
	Physici /Medic		DONALD				LEWIS		April	27	200	4 11	12 AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, 1	Town, or Localion	of Death		4c.	County of Dea	ath	
			The Johns +	topkins Hos	steah	150		Ke	City				
	Funeral Director		5. Social Security Number 243–18–9434 6. S	7. Age (In yrs/ M 2 F 85	last birthday) Yrs.	If Under Months	1 Year   If Under Days   Hours	Min.	8. Date of Birt (Month, Da July 1	y. Year)	918 9. Bi	rthplace (Star Country)	e o <i>r F</i> oreign unk
	D >		Usual Residence of Decedent  10a. State 10b. County	10c Cit	ty, Town or Lo	veation						10d Inside	City Limits
	shov	7	MD 100. County	100. 01	-	imore							es 2 No
	28a-f	Director	10e. Street and Number			10f. Zip				10a Citis	en of Whal C		
	with the party of		908 Belnord Aven	1110		TQI. Zip	21205			rog. Oilia		1	
	s 23	era	11. Marital Status	12. Was Decedent Ever in U	S 13 V	Was Deced			cify Yes or No		U 4. Race - Am	SA Jerican Indian	
21215-0036	within 72 hours efter death with the Maryland ene. than "naturel", or tems 23e or 28a-f show fre Madical Examiner must be indiffical at	by Funeral	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	unk	lf Yes, speci 1 ☐ Yes 2	ent of Hispanic Or ify Cuban, Mexica		Rican, etc.)		Black, Wh Specify:		
ğ	2 hou	ed	15. Decedent's Ed		16a. Deced	dent's Usua	Occupation		unk	16b. Kir	nd of Business	s/Industry	unk
72	n n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give	kind of won DO NOT us	l Occupation k done during mo: e retired)	st of workii	ng				ulik
2	d with	mo:	1	nk									
land	uld be file fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last)			1	unk 18. Moth	ier's Name	(First, Middle,	Maiden .	Sumame)		unk
Mary	nd 2 sho Ith and h 27 le ma r trauma		19a. Informant's Name/Relationship (Tohns Hopkins Hos	**	1	•	(Street and Numb						
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, Ira Madical Examinar must be intillised at once.	100	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☑ Other (Specify	Removal from State	Place of Dispo cemetery, cren	isition (Nam	e of	D	ate	20c. Lo	I) ZIZ⊠ cation - City o	r Town, State	ı
Balt	permit. Departn Importe any inju		21. Signature of Euneral Sen ice Licen	// I I TAKE X	1	tate	Anatomy	Board			ltimore	e Stre	et
	Prrysician		23a. Part Enler the disease, or composition shock or heart failure. List only Immediate Cause (Final disease or contilion	plications that caused the deat one cause on each line.	th. Do not ent	er the mode	of dying, such as	s cardiac o	r respiratory ar	rrest,		Approximinterval I	Between
	/Medical		resulling in death)	a Due lo (or as a consec	quence of):							INC	DAIS
	Examiner	Jer	Se uentially list conditions if any, leading to immediate	b. PNEUMON								ONE	WEEK
8760,	cate be executed obysician and the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consec	quence of):								
687	icate phys	edicai		0.					-				
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<u>α</u>	hat the deby detac	Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying ca	use given in Part	I.	23e. Did to	obacco us	se contribute	to the cause	of death?
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0	lavi requires that as oeen signed b 2 should be deta	etec											
Il Records,	The ate h	Completed							24a. Was autop perfo 1 Tyes		prior to death?	utopsy findin completion o s 2 \( \sum \) No	gs available if cause of
Vital	yslcien: The is certificate director, pag	Be	25. Was case referred to medical examiner?	1124-1				e of Death	(Check only o	ne)			
5	S S	은	1 ☐ Yes 2 No		ER/Outpatier			_	ne 5 Resid			ecify)	
ū	ing P	on:	27. Manner of Death  1   Natural 5   Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	1	3c. Injury at Work?		28d. Describe h	now injury	occurred		
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2			2.			
Division of	in Sir	Certification:	4 Homicide determined	28e. Place of Injury - Al h building, etc. (Speci	ome, farm, str fy)	reet, factory,	, office		28f. Location (5 City or Tov			Rural Route N	umber,
	To the Hoepitel or within 24 hours after To the Funerel Dirticompletely filled in It	edical		ysicien: To the best of my kno niner: On the basis of examina and manner stated.									e(s)
	To the vithin To the comp	Ň	29b. Signature and title of certifier				License number				signed (Mon		
			Sattelaise	Pue MD		1	RES - 0	00		APR	211 2	27 2	004
			30. Name and address of person who	completed cause of death (Iter	т 23а) (Туре,	Print)	J	DHNS	S HOPK	INS	Hospi	TAL	
			30. Name and address of person who IVESATTA MASSAQ	UOI. 600 NOR	TH WOL	FE S	TREGT	BAL	TIMORE	F. A	JARYLI	AND 2	1287
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 1 2004	82. Registrar's Sign	atur.	par	2						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Year Physician MAI 2004 Edward George Leonard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Agnes Hospital Baltimore 8. Date of Birth (Month, Day, Year) 05/24/1928 If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 218-22-2087 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f ahow other traumatic avant, the McCleal Examiner aust be notified at 1 ☐ Yes 2 XNo Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 2 McIntosh Ct. Apt. I 21228 **United States** itams 23g Completed by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? TYes 2 □ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🕱 No Specify: White Specify: Year or Dates: unknown 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Checker Steel Production 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file ment of Health and Mental Hy ant: If item 27 is marked oth jury or other traumatic avant Be unknown 2 unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norene Parthree / ex-wife 1 J Winesap Ct. Apt. J Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State permit Page Department of Impor ant: If any injury or once. 5/10/2004 Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licer 1328 Sulphur Spring Rd. Baltimore, Maryland 21227 semblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or samplications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final ocardia, Pnysician das disease or condition resulting in death) /Medical a consequence of): Disease Examiner ar CONON man tingly flat or milltime. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ★ Yes 2 □ No 24a. Was an autopsy performed? TU 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 27. Manner of Death 1 ANatural 2 Accident 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To tha Funaral Diractor: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 056226

State Registrar

Ballo

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D. 900 caton

BalT. More

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAMEND JTTEM #26 PER PHY C831 5/11/04 Contribute of Death Reg. No. 2004 Decedent's Name (First, Middle, Last) 2. Date of Death Day Year JOYCE B LONG 27 April 5:20 p M 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2305 E PRESTON STREET BALTIMORE N/A 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X Months Days Min Yrs. 217-68-0860 44 MARYLAND NOV. 12 1959 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2305 E PRESTON STREET 21213 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 微XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. XXNever Married 2 Married 1 ☐ Yes 2 Ho Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

DISABLED

20b. Place of Disposition (Name of

2ea. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of):

cemetery, crematory or other place)

CEDAR HILL CEMETERY

22. Name and Address of Facility

systemu lupus erythematosis

1206 W NORTH AVENUE

N/A

20c. Location - City or Town, State

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No

3 Probably 4 Unknown

GLEN BURNIE, MARYLAND

Approximate Interval Between Onset and Death

141

21224

18. Mother's Name (First, Middle, Maiden Surname)

1669 Cliftview Avenue, Baltimore, Maryland 21218

WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.

OLA MAE LONG

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

05-06-04

death with the Maryland or 28a-f show item 27 Is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examinar must be notified at Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Ite Baltimore, Maryland 21215-0036 permit. Pages 1 Department of H Important: If ite any injury or ot once.

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be ို

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Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

RUFUS SCOTT

20a. Method of Disposition

mediate Cause (Final

Sequentially list conditions, if any, leading to immediate

31. Date filed (Month, Day, Year)

MAY 1 1 2004

disease or condition resulting in death)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

LaShaunda Womack/Daughter

of Fune/al Service Licensee

1 Burial 2 □ Cremation 3 □ Removal from State

12yrs

21. Signaty

College (1-4or 5+)

yrs

**Funeral** 

Director

Priysician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit has e 2 certificate has Director: / filled

within 24 hours a the

Division of Vital Records, P.O. Box 68760.

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consect	quence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 Ectopic p			23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
				24a. Was an autopsy performed:	
25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 22	ER/Outpatient 3 □ D	Other	eath <i>Check on one</i> Home <b>v</b> Residence	6 □Other (Specify)
27. Manuer of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factor fy)	y, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier (Check only one) Certifying Phy	/sician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place in, in my opinion, death occ	ce, and due to the cause curred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29	c. License number	29d. [	Date signed (Month, Day, Year)
			033307	-	14/04

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2000 14943 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year LIGON Month **Physician** 1242 AM 2004 JOHNNIE MAY /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOPKINS BAYVIEW CARE CENTER JOHNS BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 X F Texas 213-07-9723 93 11-06-1910 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 17 Yes 2 No Director NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5505 Hopkins Bayview Circle 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No 1 Never Married 2 ☐ Married 1□Yes 2⊠No Maryland 21215-0036 Specify δ 3 XWidowed 4 ☐ Divorced Year or Dates: **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: If item 27 is marked other than 'ury or other traumatic event, item Me Elementary/Secondary (0-12) College (1-4or 5+) 8 Domestic Housekepper 18. Mother's Name (First, Middle, Maiden Sumame) unknown 17. Father's Name (First, Middle, Last) unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 N. Calvert St. Suite 300 Balto, MD 21202 Alice Bellamy/ Guardian Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or ance. Metro Crematory 05-08-04 Catonsville, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Sovice Licensee 22. Name and Address of Facility Wylie Funeral Home 638N. Gilmor St. Balto, MD21217 Ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai as the the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year for Month Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by hypertonson, arthritis, Vascular Accident, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 X No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Medical Certification: To 1 Yes 200 No 3 DOA After this c funeral dire 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural 1 Yes 2 No s after death.
If Director: A
id in by the fu death. investigation 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D56705 May oth , 2004 failelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYVIEW (IRCLE, BALTIMORE MD 21224 GAJADHAR, 5505 HOPKINS RACHELLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 1 2004

		•	For State Registrar		State o	f Marylan		rtmen <i>tificat</i>			and M		giene Reg. No.	200	4 140	A la la
ı	Physicia		1. Decedent's Name (First	, Middle, Last, SHARO				LAZE <i>A</i>	ıR			2. Date of Dea Month MAY	Day 9,	20Ŏar	3. Time of D 1:38	
	/Medic Examin		4a. Facility Name (If not in:	stitution, give	street and nu	mber)				Location o		) C		County of Dea	ath	
	Funeral		JOSEPH RIC 5. Social Security Number	6. Se	K	7. Age (In yrs.		If Under	1 Year Days	If Under a	Min.	8. Date of Birth	v. Year)	9. Bi	N/A rthplace (State or I	Foreign
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	faryland show	or	MD 10a. State 10b. 0	County N/A		10c. Cit	y, Town or Lo	cation IMORE							10d. Inside City 1 ☑ Yes 2	
	or 28a-1	Funeral Director	10e. Street and Number	N/ A			DALI	10f. Zip	Code				10g. Citiz	en of What C	^	
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09/89	certificate be executed iding physician and ise as the burial-transit	edical		•	d											
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ecoras	require						-					1 🗆 Y		_	robably 4 🗆 Uni	
итан жес	The lay ate has page 2	e Completed	25. Was case referred to	modical									sy med? 2 No		utopsy findings av completion of cau s 2.2 No	
\   \   \	d is	To Be	examiner? 1 ☐ Yes 2 No	_		Inpatient 2	ER/Outpatien	t 3 🗆 DC	A Othe			(Check only or ne 5 ☐ Resid		Other (Spe	ecity) Hospi	CE
	ffei	ation:	27. Manner of Death  1 SNatural 5   2 Accident	Pending investigation	28a. Date (Mon	of Injury ith, Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y	at ? 'es 2 ∐ l'		8d. Describe h	ow injury	occurred	,	
UNISION	or Attandidater death. Director: All in by the fu	ertifica		Could not be determined		e of Injury - At h		eet, factory	, office		2	28f. Location (S City or Tow	treet and n, State)	Number or R	ural Route Numbe	91,
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	within Comp	Me	29b. Signature and title of	certifier	2	$\sim$		290	License	number	j	2	29d. Date	signed (Mon	/2004	Ĺ
	1,8		30. Name and address of	A Bran	ompleted cau	se of death (Iter	n 23a) (Type,	Print)	ک اما	7 3	RAI	LTIM	دامه	FM	A 217	01
•	Sta Registr		31. Date filed (Month, Day	2004		Registrar's Signa	6	port	1	, ,		1.5	- 1 -			~

			For State Registrar	State of Mary	yland /	•	rtment of I tificate of			Re	g. No. 200	4 14945
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Loretta Mary	Lyons					Ma	Date of Death Month ay 7,	Day Year 2004	3. Time of Death? 7:48 A M
	Examin Funeral	er	4a. Facility Name (If not institution, give state)  25 Thomas Road  5. Social Security Number  6. Sex		in yrs. last	<i>birthday)</i> Yrs.	4b. City, Town, of Glen But If Under 1 Year Months Days	rnie	24 Hrs. 8. [ Min.	Date of Birth	Anne Art	undel httplace (State or Foreign country)
1	Director  woye  work  wo	or	439-16-8528  Usual Residence of Decedent  10a. State  10b. County  Maryland Anne Arun	10	85 oc. City, To Glen	own or Loc			S]	EPT 7,	1918 Lo	Jisiana  10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	permit. Pages 1 and 2 should be lided within 72 hours after death with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if time Z7 is marked other then "naturel", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	Funeral Director	10e. Street and Number 25 Thomas Road				10f. Zip Code 21060		-i-0 (Cif.		USA	
9500	urel', or Items	þ	11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:		1	Vas Decedent of li Yes, specify Cub ☐ Yes 21 No	Specify:	gin? (Specify i, Puerto Rica	n, etc.)	14. Race - Am Black, Wh Specify:	White
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lore, Ma	iges 1 end 2 it of Health a : If item 27 is or other trei		Celina Christianse  20a. Method of Disposition  1 Burial 2 Cremation 3 Be	1	20b. Place ceme	of Dispos etery, crem	homas Ro sition (Name of natory or other pla	ісе)	Date		20c. Location - City o	r Town, State
Baltimore	permit. Pa Departmer Importent any injury once.		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Liganse  Thomas Gregor		Metr	22 C	ematory Name and Addr Jemation 99 Frede	Soci	5-8-04 ty of koad	MD. I	Baltimore, nc. more, MD	MD 21228
	hysician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.  STRO  Due to (or as a co	ME	•	er the mode of dy	ng, such as	cardiac or res	spiratory arre	st,	Approximate Interval Between Onset and Death
	ie be executed ysician and e burial-transit	licai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								
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coras, P	w requires that the de been signed by the s should be detached	þ	Part II. Other significant conditions con	ributing to death but n	not resultin	g in the ur	nderlying cause g	ven in Part I.			s 212No 3 P	o the cause of death?  robably 4 □Unknown  utopsy findings available
<b>P</b>	lysician: The law iis certificate has b director, page 2 sk	Be Completed	25. Was case reterred to medical examiner?							autopsy perform 1 Yes 2	prior to death? No 1 □ Ye	completion of cause of
_	ig Physiter this	Certification; To	27. Manner of Death  1	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Yo	ear) 281	b. Time of Injury	28c. Inju Wo M 1		No	Describe ho	nce 6 Other (Spewinjury occurred	
	0 # # S		4 Homicide determined  29a. Certifier 1 Certifying Phys	28e. Place of Injury building, etc. (s ician: To the best of n er: On the basis of ex	Specify)  ny knowled	dge, death	occurred at the t	ime, date and	d place, and	City or Town,	use(s) and manner a	s stated.
	In the Hospitel within 24 hours a To the Funeral E completely filled i	Medical	29b. Signature and hite of certific	and manner stated	<u>.</u>			se number	<i>‡</i>	29	Od. Date signed (Monday 7, 200	th. Day, Year)
	X		1 / 1 1	our fur	K	On	Print) (10	Bul	alt,	ud.	2106/	
	Sta Registr		31. Date (Mati/Nenth, Day, Year)	32. Registrar's	Signature	1	have-		,			

			1 - For State Registrar	State of Maryla	•		nt of He		•	giene Reg. No	2001	1491
П	Physici	an	Decedent's Name (First, Middle,  Vo.cumi  No.cumi  No.cumi						2. Date of De Month MAY	ath Da	2004 Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,	McMillian		4h City	Town or	Location of Death	<u> </u>		ZUU4 County of Death	8:00p M
	Examir	ier	Crofton Conva	•		45. Oily		fton			Anne A	rundel
	Funeral Director		495-56-6478	3. Sex 1	: last birthday) Yrs.	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da APR 19	th ly, Year,	9. Birthp Coun 930 Japa	lace (State or Foreign try)
	land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation					1	Od. Inside City Limits
	Mary 1-fsh	to	Maryland An	ne Arundel		Cro	fton					1 □Yes 2 🟋No
	or 284	Jirec	10e. Street and Number				p Code			10g. Ci	itizen of What Coun	try?
	s 23a	Funeral Director	2806 Erics Cour				211				USA	
10	ter de	-une	11. Marital Status  1 □ Never Married 2 □ Marrie	12. Was Decedent Ever in t Armed Forces? d 1 ☐ Yes 2 💆 No	J.S. 13.	Was Dece If Yes, spe	dent of His cify Cuban	spanic Origin? (Si n, Mexican, Puerto	Rican, etc.)	)-	14. Race - Americ Black, White,	
036	72 hours after deeth with the Maryland naturel', or items 23a or 28e-f show disal Examinat must be notified at	þ	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 <b>∭</b> No	Specify:			Specify: AS	sian
21215-0036	72 hc	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	kind of wo	ork done di	urina most of wor	king	16b. K	Cind of Business/Inc	dustry
121	within ene. than	Jup	Elementary/Secondary (0-12)	College (1-4or 5+)		amst	retired)			Doz	nortmont	Chama
	i Hygi other	Be Co	17. Father's Name (First, Middle, L	ast)	1 50	-camo c		18. Mother's Nam	e (First, Middle,		partment Sumame)	Store
/lar	uld be Menta arked	To B	Akikata Mito	0				Setsuk	o Tsuts	umi		
Maryland	2 sho and I Is ma		19a. Informant's Name/Relationshi		19b. Mailir	ng Address	s (Street ar				or Town, State, Zip	Code)
	1 and Health em 27		Mary Cooper/daug	20b.	Place of Dispo	sition (Na	s Cou me of		ton, MD	211 20c. L	.ocation - City or To	wn. State
nor	ages ant of it: If it		1 ☐ Burial 2 ☐ Cremation : 1 ☐ Donation 5 ☐ Other (Spe		<i>cemetery, cier</i> etro Cr			Inc. 5/6	/04		Baltimore	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with tha Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at anone.		21. Signature of Furer   Service L	C . A			• -	Society				, FID
m	Depa Impo any is		Dawin F.	McDonald	2	99 F	reder	ick Road	Balti	more	. MD 212	28
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused the dea nly one cause on each line.				17		rrest,		Approximate Interval Between Onset and Death
7	Pnysician /Medical	H	Immediate Cause (Final disease or condition resulting in death)	-a. MUI		2	Sc	lero	SIS			Ondot and Dodg.
	Examiner			Due to for as a conse	quence of):						1	
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyling Cause (Disease or injury that initiated events	b. Due to (or as a conse	quence of):							
	ecutar and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	quenes of):							
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai E		Due to (or as a conse-	quence ory.							
9	ificate g phy: as the	edic		d		-						
Box	th cert endin r use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic p	regnancy				23d. Date of delive	•
.O.	es that the death certifica igned by the attending pr be detached for use as th	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (s)					Month	Day Year
Ω.	that the ed by detac	/ Ph)	Part II. Other significant condition	s contributing to death but not re	sulting in the u	nderlying o	cause giver	n in Part I.	23e. Did to	obacco	use contribute to th	e cause of death?
Records,	quires n sign uld be	q pa							101	res 2	□No 3 □ Proba	ably 4 Unknown
000	law require as been sly 2 should b	Completed							24a. Was		24b. Were autop	osy findings available
Œ.	iicien: The lav certificate has rector, page 2	Com							perfo	rmed? 2 No	death?	2□ No
Vital	icien: certific rector	Be	25. Was case referred to medical examiner?	Hospital:			Othor	26. Place of Dear				
o	Physic this stal dis	: To	1 ☐ Yes 2 XNo 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	-	28c. Injury	4 X Nursing Ho	ome 5 Residence 128d. Describe 1		6 ☐Other (Specify ry occurred	)
ion	ttending F death. ctor: After y the funar	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Injury	М		? es 2 □ No				
Division	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Diractor: After this certificate h completely filled in by the funaral director, page	Certification;	3 Suicide 6 Could no 4 Homicide determin		nome, farm, str ify)	eet, factor	y, office		28f. Location (S City or Tox	Street an vn, State	nd Number or Rural e)	Route Number,
	ppitel ours a leral C		29a. Certifier 1 Certifying	Physician: To the best of my kn	owledge death	occurred	at the time	date and place	and due to the	causo/s	\ and manner as et	atod
	e Hos 124 ho e Fun letely	Medical	(Check only 2 Medical E	xaminer: On the basis of examin and manner stated.	ation and/or in	vestigation	i, in my opi	nion, death occur	red at the time,	date and	d place, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		^		c. License				te signed (Month, L	
	1-		1 (Ritak	. Stick 1	W		DE	2025	>	5	16/20	04
	5		30. Name and address of person w	ho completed cause of death (Ite	m 23a) (Type,	Print)	21 1 1	27 45	2010	111~/	of run	06+ 20707.
	Sta	te	31. Date filed (Month, Day, Year)	l 32. Redistrar's Sign	ature	145E	VIK	UHC	ر ا	C 241 6	<u>م / ق</u>	
	Registr		MAY 1 1 200	4 Germa	4	1						

DHMH 17 Rev 1/2001

ORIGINAL

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RESIDENCE

28b. Time of

FOUND 10:55AM

28c. Injury at Work?

1 Yes 2 No

Year

Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6 Mother (Specify) At Scene

SUBJECT FOUND KANGING

28f. Location (Street and Number or Rural Route Number, City or Town, State)

May 3, 2004

4507 FAIRFAX RO, BALTIMORE, MD

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

Division of Vital or Attending

2

Certification:

After this

after death Director: /

death.

28a. Date of Injury (Month, Day Year)

5/2/04

Hospital:

2 No

5 Pending investigation

6 Could not be

1 XYes

27. Manner of Death

2 Accident

3 Suicide 4 ☐ Homicide

1 Natural

29a Certifie

Mark Miller 04-03108 MAN 1 - For State Registrar

# u

npend Iten#23a,27,28a-f,PR MF,0831,5/27/04ex Please Type or Print in Black Indelible link. Ensure Al	l Copies Are Legible.	
State of Maryland / Department of Health and M  Certificate of Death	fental Hygiene 2004	14949
ne (First, Middle, Last) Mark Miller	2. Date of Death Month Day O7, 2004	3. Time of Death 2020 A M

**Physician** /Medical **Examiner** 

**Funeral** Director

the Maryland item 27 is marked other then "neturel", or items 23a or 28e-f ehow other traumatic event, the Medical Eventral rates by notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is marked other then "neturel", or Itel = 5 permit. Page Department of Important: If any injury or once.

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records.

Physician /Medical Examiner

Hospitel or Attending Physicien: The law requires that the death certificate be executed burialthe as has dire After death. Director: within 24 hours a To the Funerel I

 Decedent's Nar 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death N/A 1347 Clipper Heights Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**∑**M 2□ F Months Days 218-58-7108 Yrs. 50 May 1, Marvland Usual Residence of Decedent 10b. County 10c, City, Town or Location 10a State 10d. Inside City Limits MD N/A Baltimore tyTYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 1343 Clipper Heights Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ X XX If Yes, Give Year or Dates: XX Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
N/A 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10th College (1-4or 5+) N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Miller Letha Miller Cassell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Letha Miller (Mother) 2106 Lugine Avenue Balto, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Balto/Wash Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX emation 3 ☐ Removal from State 5/11/04 Laurel, MD Other (Specify) ° 4 □ Donation 5 □ 21. Signator Frankervic Lo 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home 11
3631 Falls Road Balto, MD 27211 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Medithadone Intoxication disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an autopsy
performed?

1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Other (Specify) At scene 2 1XXes 2 □ No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation fourt 5/7/04 ar) 1 Natural found 8:00p 2 Accident Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide found at home 1347 Clipper heights Ave., Baltimore, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical XXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 08, 2004 un umprile Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

MAKYDONTA

31. Date filed (Month, Day, Year)

1 2004

111 Penn Street, Baltimore, Maryland 21201

KORELL

			1_ For State	State of Ma		Depai	rtment		th and N	Mental Hyg	giene ,	2004	149	50
			Registrar			Cert	iiiCate	OI Dea	tu i	2. Date of Dea	Reg. No. 6		3. Time of De	oth.
	Physicia	20	Decedent's Name (First, Middle, Las							Month	Day	Year	3. Time of De	MA.
	/Medic		JASON LE	E Mc C	RONE					MAY 07			4:57 P	) <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, 1	Town, or Local	tion of Death		4c. Co	unty of Death	)	
			10 WHORL COURT					'IMORE		,			COUNTY	
	Funeral		5. Social Security Number 6. Se		(In yrs. last		If Under		nder 24 Hrs. urs Min.	8. Date of Birtl (Month, Day	/, Year)	9. Birth	place (State or Fountry)	oreign
	Director		189-54-0985	<b>X</b> M 2□ F	32	Yrs.				Nov.28	1971	Pe	nna.	
	<u>p</u>		Usual Residence of Decedent		10c. City, To	05100	ation						10d. Inside City L	limits
	show thow	_	10a. State 10b. County	- C-						_			1 Tes 2	
	A Paris	cto	Md. Baltimor	e co.	Daı	timo:								-7\.
	9 2 E	Director	10e. Street and Number				10f. Zip					of What Co	untry?	
	death with the Maryland rms 23a or 28a-f show rmust be notified at	al	10 Whorl Court				L	21221				.S.A.		
	sep su	by Funeral	11. Marital Status	<ol> <li>Was Decedent E Armed Forces?</li> </ol>	ver in U.S.	13. W	as Deced Yes, spec	ent of Hispani ify Cuban, Me	c Origin? (Sp xican, Puerto	pecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
0	afte or It	币	1 Never Married 2 Married	1 ☑ Yes 2 ☐ No It Yes, Give	0	1	☐ Yes 2	No Spe	ecity:		Sp	ecify: wh	ite	
3	n 72 hours after death with the Marylar *natural', or Items 23a or 28a-f show		3 Widowed 4 Divorced	Year or Dates:						1				
ก็	72 F	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	(Give k	ent's Usua and of wor ONOT us	Occupation k done during	most of work	king	160. Kind	of Business/I	noustry	
V		du	Elementary/Secondary (0-12)	College (1-4or 54	+)							1 10		
٧	led v lygie her t nt, Ib		12 17. Father's Name (First, Middle, Last)	+2		State	e Tro		Anther's Nam	ne (First, Middle,		land S	tate	
yand	tal H d otl	Be	Donald	McCron				_						
Ž	2 should be filed within and Mental Hygiene. Is marked other then aumatic svent, Ins M.	L <sub>O</sub>							tricia			ill	in Code)	
la l	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Ins. M. 900ce.		19a. Informant's Name/Relationship							ral Route Numbe			ip Code)	
a) E	and ealth m 27		Heather McCrone	(Wif	20b. Place					imore, M		221 tion - City or	Town State	
0	of H of H if ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	ceme	tery, crem	atory or of	ther place)	1		200. Loca	tion - City of	Own, State	
банттог	Pag ment ant: ury c		* 4 ☐ Donation 5 ☐ Other (Specify	)	Mary	-				/12/04	Crow	nsvil	Le, Md.	
	permit. Depart Import any inj once.		21. Signature of Funeral Service Licen		//	3	3.4 4	d Address of F	7 7 .	ak Funer	-o1 He	mo D		
0	205 = 3		Jaco Si	Xam	mo		320	9 <del>4 Монг</del>	itain	Road. Pa	sader	na Md	21122 Approximate	
			23a. Part1. Enter the disease, or commodox, or heart failure. List only	plications that caused one cause on each lin-	the death. D	o not ente	r the mode	of dying, suc	h as cardiac	or respiratory ar	rest,	,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Buck	1 #;		Now					1	Onset and Dea	ths.
	/Medical	6	resulting in death)	Due to (or as a	consequen		-011							
	Examiner		Convention list appointing	b										
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	ce of):								
	be executed ician and burial-transi	Examiner	Cause (Disease or injury that initiated events	C										
Ď	execan an an an rial-ti		resulting in death) Last	Due to (or as a	a consequent	ce of):								
-	ysicia e bu	cai		d										
ρ	death certificate e attending phys id for use as the	ed												
ROX	andin use	S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		ath 3∏i	Ectopic pre	agnancy			230	f. Date of deli		
	deati e atte d for	icla	in the past 12 months? 1 ☐ Yes 2 ■No	4☐Pregnant at			Other (sp					Month	Day Yea	ar
j.	by the	Physician/Medi	9 Unknown	9⊡ Unknown										
7	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resultin	g in the un	derlying ca	ause given in I	Part I.	23e. Did to	obacco use	contribute to	the cause of deal	ith?
Vital Records,	quire n sig uld b									101	res 2 K	No 3□Pr	bably 4 Unk	known
<del>ွ</del>	w rec	Completed								24a. Was		24b. Were au	topsy findings ava	ailable
T T	he la e has ige 2	m									rmed?	death?	ompletion of caus	se or
Ø		e Co	25. Was case referred to medical					26	Place of Dea	1 ☐ Yes th (Check only o	2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	200 NO	
5	ysicien: The law iis certificate has t director, page 2 s	00	examiner?	Hospital:	nt 2 ER	Outpatient	3 DO	Other		ome 5 Resid		Other (Sne	26.1	
Ö	Phy r this ral d	- T	27. Manner of Death	28a. Date of Injur	y 28	b. Time of		8c. Injury at Work?		28d. Describe I				
0	ding Ph h. After th funeral	tior	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	М	Work? 1 ☐ Yes	2 🗆 No					
Division	deal ctor: y the	Certification:	3 Suicide 6 Could not b	e 290 Place of Inju	ury - At home	, farm, stre	et, factory	, office		28f. Location (S	Street and f	Number or Ru	ral Route Numbe	ır,
	after Dire	ertil	4 Homicide	building, etc	. (Specify)					City or Tov	vn, State)			
	pours ours ours ours filled		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowle	dge, death	occurred	at the time, da	ite and place	, and due to the	cause(s) ar	nd manner as	stated.	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely illed in by the funeral director,	Medical		niner: On the basis of and manner sta	examination									
	ithin o the omple	₩ We	29b. Signature and title of certifier				290	. License num	ber		29d. Date s	signed (Monti	o, Day, Year)	
)	F 3 F 5		March 2	Mr	, PL	0		D600	2412		Mr.	10	Hage	
	X,		30. Name and address of person who	completed and at a	eath (Itam 00	a) (Tuna I	Print1	2000	0 14		, iai	1 10	000	
	10,		30. Name and address of person who	M.D. CA		ol Kr	-th	Broad	s alter	Beltina	ore 1	4001	mil 212	121
		ate	31. Date Herdy (Meinth Day Keng)	54_32 Podistra	ar's Signature	10	24 1	-3.000	may 1		3. ( )	1001410	W- 40. D. 19	
	Regist		MAT 1 1 2004		1	1 1								

			riease i	State of Manuar					•	9.
			1 State	State of Marylar	•		nt of Health and ate of Death		000	11 11 051
			Registrar  1. Decedent's Name (First, Middle, Last)	)	Ce	Tunca	ne or Dearr	2. Date of Dea	eg. No. 20	3. Time of Death
E	Physici /Medi	cal	EUS WORTH 1	Franklin	M	1	SHALLI	Month	Bay Zo	04 1200 pm
	Examir	er	4a Facility Name (If not institution, give s		AL	K	y, Town, or Location of Deat	ZE		ore City
4	Funeral Director		221 00 1270	-0-	last birthday) 53 Yrs.	Month	er 1 Year If Under 24 Hrs s Days Hours Min.	8. Date of Birth 6/16/19	40 9.	Birthplace (State or Foreign Country) MD
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne Arus		ty. Town or Lo	ocation asad	ena			10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28a	i Director	10e. Street and Number 8249 Bodkin Avenu	e		10f. 2	Zip Code 21122	1	0g. Citizen of What	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. titam 27 is marked other than "natural", or itsma 23s or 28s-f show other traumatic event, the Medical Evantinal must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:			sedent of Hispanic Origin? (Secify Cuban, Mexican, Puerlo 21) No Specify:	pecify Yes or No- o Rican, etc.)		umerican Indian, Vhite, etc. white
Maryland 21215-0036	within 72 ho iene. 'than "natur i's Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12)		(Give	kind of	tual Occupation work done during most of work use retired)	king	16b. Kind of Busine	company
/land	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) Ellsworth Frankli	n Marshall II				ne (First, Middle, I d Greenf		•
	1 and 2 sho Health and I tam 27 is me		19a. Informant's Name/Relationship (Ty, Mrs Elisabeth C Ma				ss (Street and Number or Au in Ave., Pasa		City or Town, State 21122	e, Zip Code)
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Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service License	dellas mois	3641	Seco	and Address of Facility Sind Ave SW Gle	ngleton : n Burnie	Funeral H , MD 2106	ome 1
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.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be defached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1	Il death 3	⊒Ectopic ] Other (	pregnancy specify)		23d. Date of Month	delivery Day Year
<u>α</u>	uires that signed b ld be deta	by	Part II. Other significant conditions con	itributing to death but not res	ulting in the u	nderlying	cause given in Part I.	23e. Did tob		e to the cause of death?  Probably 4 Unknown
of Vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	y prior !	
Z.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			l out	th Check on one		
		on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		OOA	ome 5 Reside 28d. Describe ho	nce 6 Other (S	pecify)
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Q	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.		29a. Certifier  (Check only Check only 2 Medical Examin	sician: To the best of my kno	owledge, death	occurre	d at the time, date and place	and due to the ca	use(s) and manner	as stated.
	To the H within 24 To the F complete	Medical	Site)	ner: On the basis of examina and manner stated.	ttion and or in					
	₩ 5 ½ 5 g		29b. Signal with little of certifier	M.). F	( )	2	60211	29	od. Date signed (Mo	07 7am/
	10		20. Name and address of person who co.	mpleted cause of death (Item)	n 23a) (Type,	Print)	AI) WAY	BALTI	MORE,	MD 21231
9:	Sta Registr	re.	31. Date filed (Month, Day, Year)  MAY 1 1 2004	32. Registrar's Signa	dure	Spo	uts)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Month : 35 P. M **Physician** Margaret 20 2004 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard

9. Birthplace (State or Foreign Country) Howard County Hospital
5. Social Security Number 6. Sex 7. A Columbia
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Age (In yrs. last birthday) **Funeral** 055-10-5292 1□M 2XX Yrs Director 88 Sept. 27, 1915 New York Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 ☐ Yes 🎖 No MD, Howard Ellicott City Direct 10e, Street and Number 10f. Zio Code 10g, Citizen of What Country? 10097 Colonial Drive 21042 Funerai 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner of 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specifwhite Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Schools Public permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: if item 27 is marked other the my injury or other treumatic event, Line ODE. teacher New York 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Thomas McKenna Barbara Dougherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4719 Leyden Way, Ellicott City, Md.21042 Frederick P. Murphy/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Balto/Wash.Crematory 5/5/2004 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd, Columbia, Md. 21045 23a. Part1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tno **Physician** Stage ranal /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): burialby Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No for 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Doma 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Momicide

The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records,

physician

or Items

natural

than

filed within 72 hours after

Baltimore, Maryland 21215-0036

To the Host itel or Attending Physicien: : After thi death. Director: within 24 hours after To the Funeral Direct  $\mathcal{O}$ 

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 1 1 2004

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

M.O.

rson who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kevin McAndrews **Physician** Month 5:00 a.m May 7, 2004 Year /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 12018 Livenston St. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) May 14, 1957 Birthplace (State or Foreign Country) **Funeral** 10 M 2□F 46 000-50-6050 Usual Residence of Decedent Yrs Director Pennsylvania 10a. State 10b. County 10c. City, Town or Location Itams 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Maryland Mntgomery Silver Spring 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20902 12018 Livenston St. U.S.Á Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No 1□Yes 2No -Baltimore, Maryland 21215-0036 White þ Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Television than ' Elementary/Secondary (0-12) College (1-4or 5+) Video Editor other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event gotes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John McAndrews Margaret City 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11066 Dorsch Farm Rd. Ellicott City, Maryland 21042 Mr. Terrence McAndrews Brother 20a. Method of Disposition
1 □ Burial 2 ★Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 05/12/2004 Baltimore, MD **Bayview Crematory** 22. Name and Address of Facility Slack Funeral Home, P.A. 3671 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licensee 23a. Part1. Exter the disease, of compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kespiraton **Physician** /Medical Due to for as a consequence of) Examiner 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medicai the asi IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ed by the atter detached for i 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Be Completed by 25 No 3 Probably certificate has been s rector, page 2 should 4 I Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA o 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of or Attending After Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide o the Hospital Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Collect DC 12582 completed cause of death (Item 23a) (Type, Print) Dasherieton Hospital George 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 1 2004 Registrar

			For	State of Maryland	Department of Health ar	nd Mental Hygie	ene	Lion
			1 - Stata Registrar		Certificate of Death		. No. 2 UU4	14954
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	Examin	er	4a. Facility Name (If not institution, give	1/.00	4b. City, Town, or Location of		4c. County of Death	
-			5. Social Security Number 6. Se	0 U P-5 HOS (1 ix 7. Age (In yrs. last	110	MORE Hrs. 8. Date of Birth	9/Birthol	ace (State or Foreign
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	nylan how		10a. State 10b. County	10c. City, To	own or Location		10	Od. Inside City Limits
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	or 2	Funeral Director	10e. Street and Number	1	10f. Zip Code	10g.	. Citizen of What Count	try?
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and	uld be filed within 72 fental Hygiene. rked other than "nai tic event, 119 Med to	Be	17. Father's Name (First, Middle, Last)	11	18. Mother's	s Name (First, Middle, Mai	iden Sumanle) 1 /	
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	he Ho in 24 he Fu pletel	edical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death	occurred at the time, date	and place, and due to	the cause(s)
	To t To t com	Σ	29b. Signature and title of certifier.	Q 1.	29c. License number		Date signed (Month, D	Day, Year)
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	1		30. Name and address of person who e	pmpleted cause of death (Item 23	a) (Type, Print) RON	SECO	URCH	Spital
	Degra de	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4014	SECO	7/-3//	37150.2

Registrar

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Вох	eath certificat attending phy I for use as the	/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			∃Eatopio	pregnancy					23d. Date of de		
	deat	icla	in the past 12 months?	4☐Pregnant at				specify)					Month	Day '	rear
P.0	that the de led by the a detached f	Physiclan/Med	9 Unknown	9LI ONKNOWN											
	99 98	by	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	ınderlying	g cause giv	en in Part I.				_	o the cause of c	
Records,	w requir been si should	ted							-	— II	1 🗆 ۱	Yes 2	2∐No 3∐F	robably 4 🔃	Jokaown
ec	elawr hasbe je 2 sh	ple								_	24a. Was autop	SV	prior to	utopsy findings completion of c	available ause of
<u>~</u>		Completed									perfo 1 ⊟ Yes	rmed? 2 □ No	death?	s 2□No	
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?					To:	26. Place of	Death (C	check only o	ne)			
of \	Physi this c al dire	မ	1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatie		ER/Outpaties		-	4 Linuisi	-			6 ☐Other (Sp	ecify)	
		ü	27. Manner of Death 1°⊟Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury		28c. Injun Wor	k?		l. Describe l	how inju	iry occurred		
Sio	ten feat for: the	icat	2 Accident investigation 3 Suicide 6 Could not be		At he		M		Yes 2 □ No		Location /	Ctroot	and Morenberg and	iural Route Num	<b>h</b> a -
Division	Il or Attend after death Director: A	Certification:	4 Homicide determined	28e. Place of Inj building, et	c. (Specif	y)	reet, ract	ory, office		201	City or Tox			lurai noute ivum	Der,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filted in by		29a. Certifier 1 Certifying Pi	nysiclen: To the best	of my kno	wledge deat	h occurre	ad at the tin	ne date and r	place and	I due to the	cause/s	and manner a	s stated	
	24 hu 24 hu s Fun eteky	Medical	(Check only 2 Medicel Example)	miner: On the basis of and manner sta	f examina	tion and/or in	vestigati	on, in my o	pinion, death	occurred	at the time,	date an	d place, and du	e to the cause(s	)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				2	29c. Licens	e number			29d. Da	ate signed (Mor	th, Day, Year)	
	.\		I Was	1 ant	NN	•		NL	1705	9		M	2 8	2004	
	V		30. Name and address of person who	completed cause of d	leath (Item	23а) (Туре,	Print)		1	-		r K	7		
			Phillip Ste	ne 71	11		en '	Cho	ne L	-an	e 13	sal	timore	2004 MD 212	228
	Sta		31. Date field Months Day, Year)	32. Registr	ar's Signa	ture	200	Arra 1			ı			•	
	Registi	air				1	1	100							

			riedse	State of Maryla		ent of Health and		_	
			1 - State	State of Maryla	•	ate of Death		200	1. 11.05
		1.33	Registrar  1. Decedent's Name (First, Middle, Lasi	27	Ochime	ale of Death	2. Date of Dea	3	3. Time of Death
	Physici /Medi		Annie	Lee	Noru	100d	MAY	04, 2004	1025 pm
	Examir		4a. Facility Name (If not institution, give	1 4/		ity, Town, or Location of De	ath	4c. County of Death	VA
	Funeral		Social Security Number 6. Se		s. last birthday) If Uni	der 1 Year   If Under 24 Hi	s. 8. Date of Birth	9. Bint	pplace (State or Foreign
45 000	Director		216-14-8924	DM 2×F 9	3 Yrs. Month	ns Days Hours Mi	1. (Month, Day	-1910 Con	intry) NC
	yland sow		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Location				10d. Inside City Limits
	Ba-f st	ctor	MD N/	H	Bal	timore	,		1 Yes 2 No
	3a or 2	Funeral Director	10e. Street and Number	ere Av	-e 10f.	Zip Code 2 123 9	7	Og. Citizen of What Cou	intry?
	death	nera	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was De	cedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Amer	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Mudical Examiner rank to nuffice and	by Fu	1 Never Married 2 Married  3 Widowed 4 Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		2 No Specify:	nto rican, etc.)	Black, White	CACK
2-0	72 hou	ted	15. Decedent's Edu (Specify only highest grad	ication	16a. Decedent's U	sual Occupation work done during most of w	orkina	16b. Kind of Business/l	ndustry
21215-0036	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	orking	DAYCE	TRE CTR
	filed v Hygie other t		17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle, I	Maidan Sumame)	THE CIT
lan	Mental Kental rked o	To Be	Gable 1	selle		Be	2 Hy	Belle	_
Maryland	2 should and Men is marke		19a Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Addre	ess (Street and Number or I			
	1 and Health em 27 ther tr		20a, Method of Disposition	RRY	. Place of Disposition (A	selvedere	Aug Date	-	1021239
Baltimore,	permit. Pages Department of t important: If ite any injury or of		1 Burial 2 Cremation 3 5	Removal from State	cemetery, crematory o	r other place)	(41)4	20c. Location - City or T	own, State
altir	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licens		22. Name	and Address of Facility	10 WE11	Fulteres	Home
ä	Depa impo eny ii		Willo E	2 fources	1 460	O LIBERTY	Highs &	Bereto Mi	0 21207
Ca.			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the de ne cause on each line.	eath. Do not enter the m	ode of dying, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	и.	ENGUTTO,	mult- 1	NTARCT	-	8 445
	Examiner			Due to (or as a cons	SCLONOTIC	VASaugar	DISISSE	•	
100	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse					
7	xecute and II-trans	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a cons	equence of):				
760	ate be executed hysician and he burial-transit	calE	(	d.					
89	rtificat ng phy nas th		IF FCMALE.						
Вох	ath ce ittendii or use	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1□Live birth 2□Fe	etel death 3 Ectopic			23d. Date of deliv	ery Day Year
P.O. Box	the de y the a	Physician/Med	1 ☐ Yes 2 A No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	f death 5 ☐ Other (	specify)			
	<ul> <li>requires that the death certifica</li> <li>been signed by the attending ph</li> <li>should be detached for use as th</li> </ul>	by Pt	Part II. Other significant conditions co		esulting in the underlying	g cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
ord	requir	eted	[89VCY2	TENTUR			1 🗆 Ye	s 2 No 3 Pro	bably 4 Unknown
Vital Records,	helaw shast ge 2 s	Completed					24a. Was ar autops perform	v prior to co	opsy findings available empletion of cause of
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical			OF Place at Do	1 ☐ Yes 2	No 1 ☐ Yes	2 No
	Physici this cer al direct	To B	examiner?	Hospital: 1 ☐ Inpatient 21	☐ ER/Outpatient 3☐ I			nce 6 Other (Specia	(v)
Division of	ing Pt	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		28c. Injury al Work?	28d. Describe ho		
Sic	death ctor: /	licati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - Al	home farm street facts	1 Yes 2 No	28f Location (St	reet and Number or Rur	al Bouto Alumbos
<u>&gt;</u>	alor A s after N Direction	Certification:	4 ☐ Homicide determined	building, etc. (Spec	cify)	sy, once	City or Town		ar Houle (valliber,
	To the Hospital or Attanding Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medicai (	29a. Certifier 1 Cartifying Phy (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death occurre	ed at the time, date and place on, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as s ate and place, and due to	stated. the cause(s)
	To the within. To the somple	Me	29b. Signature and title of certifier	and mainter stated.	7 2	9c. License number	29	d. Date signed (Month,	Day, Year)
1	1		Masla (	F Thurt.	na	0203	20	Stute	cirp
	4		30. Name and address of person who co	empleted cause of death (Ite	em 23a) (Type, Print)	O 203 Scenn un			/
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	1 - 9712 /	SCEMM WAR.	BAR	- une Tr	56
	Sta Registr		MAY		Parkers A	South 2			

			1 - For State Registrar	State of Mar		artment of H rtificate of I			ne .No.2004	14957
	Physic /Medi		Decedent's Name (First, Middle, Last	Robert	Naylor			2. Date of Death Month May	/ <sup>9</sup> 9, 2004 <sup>Year</sup>	3. Time of Death 7:45 p.
	Examir		4a. Facility Name (If not institution, give 49	street and number) 14 Canvasback	c Ct.	4b. City, Town, or	Location of Death Co	lumbia	4c. County of Death Ho	oward
	Funeral Director		5. Social Security Number 6. Security 113-12-3497	7. Age (	(In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You February 15		place (State or Foreign ntry) New York
	yland now		Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town or Lo	ocation				10d. Inside City Limits
	e Man	ctor	Maryland Ho	oward		E	Ilicott City			1 □ Yes 2 No
	h with th	al Dire	10e. Street and Number 5320 Dorsey hall Dr.			10f. Zip Code	21042	10g	Citizen of What Cou U.S	ntry? S.A.
396	72 hours after death with the Maryland Instural', or Itema 23a or 28e-f show dical Exeminar must be notified at	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 Yes 22 No	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amen Black, White, Specify:	
Maryland 21215-0036	C 3	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of work.	ing 16	c. Kind of Business/In Entert	dustry ainment
d 2	e filed within I Hygiene. other than	a	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle, Mai	den Sumame)	
ylar	should be and Mental is marked o	To B	Charles	H. Naylor				Louis	e unknown	
Mar	and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationship (T)  Mr. Robert C. Naylor					al Route Number, C larksville, Ma	ity or Town, State, Zi <sub>l</sub> . r <b>yland 21029</b>	Code)
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 I		20a. Method of Disposition  1  Burial 2 Cremation 3  F  4  Donation 5 Other (Specify)	Removal from State	20b. Place of Dispo cemetery, crea		e) [		c. Location - City or To	own, State , Maryland
Baltin	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service rice is		7.1	Name and Addres	s of Facility uneral Home	e, P.A. Pike Ellicott C	City, MD 21043	
	Physician /Medical		23a. Part 1. Exter the disease or comples shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	a	he death. Do not ent	er the mode of dying		or respiratory arrest,	(	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):					
.O. Box 6	The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2: 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	ery Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	iz
Vital Records,		Completed					<u></u>	24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
of	ding Physician: Th h. After this certificate funeral director, pag	ion; To Be	27. Manner of Death  1 Natural 5 Pending	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injury Work	ar: 4 ☐ Nursing Ho	me 5 Residence 28d. Describe how		to stury
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)			28f. Location (Stree City or Town, S	t and Number or Rura tate)	Il Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Exami	sicien: To the best of ner: On the basis of ex and manner state	xamination and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pointion, death occurr	and due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
)	To th Withir To th comp	Me	29b. Signalure and title of certifier	5-9		29c. License	286	6	Date signed (Month,	
	5		30. Name and address of person who co	ompleted cause of dea	th (Item 23a) (Type,	Print) Samo bres	E Rd, Col	when his	21044	
	Sta Regist		31. Date filed (Month, Dey, Year)	32. Registrace	Signature	1.0			į.	

7:45pm

December Name (First Mode), Last BRUNTODO O'DONOVAN  Control C				_ For	i icasc						nd Mental Hy	giene	1 1 0 00 00
HELE GAIL RENITATION O'DONUVAN  *** Facility through direct residency gives where well-curbey  *** Facility through of our residency gives where well-curbey  *** Facility through of our residency gives where well-curbey  *** Facility through of our residency gives where well-curbey  *** Strong Security through of our residency gives where well-curbey  *** Facility through of our residency gives where well				1 _ State				Ce	rtificate of	Death		Reg. No.	4 14958
Account of the property of the		Physici	an								Month	Day Year	
St. Joseph Modical Center  Tousson  Tou	s i	/Medic	al					0'DO		and a section of F	1		
Social Service Name   Social Service Name		Examin	er								Death		
Description of Deceded		Funeral			ber 6. S	iex 7.		last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bit	th O.D.	
100. States   100. County   100. States   100. County   100. States   100. County   100. States					.0	□ M 21 F	64	Yrs.	Months Days	Hours	May 12	, 1939 Mai	yland
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This is a second property of the second prope		Maryl -f sho	ţ	Marvland	Baltim	ore		Towso	n				
This is a second property of the second prope		h the	irec									10g. Citizen of What C	ountry?
This is a second property of the second prope		23a o	ai D	600 Gree	nwood R	oad			2	21204		U.S.A	١.
This is a second property of the second prope		tems	nner			Armed Forc	es?	J.S. 13.	Was Decedent of H	lispanic Origin an, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)	14. Race - Am Black, Wh	
This is a second property of the second prope	2	rs afte	by F	1		If Yes, Give			1□Yes 2ሺNo	Specify:		Specify: W	hite
This is a second property of the second prope	5	2 hou atura	ted	15	5. Decedent's Ed	ducation		16a. Dece	dent's Usual Occup	pation			
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This is a second property of the second prope	7	led wi	Con	13 - 11 1 1 7 -			S	l F	Homemaker				e •,
State   Stat	2	d be fi	Be	· ·			natan						
State   Stat	<u></u>	should nd Me mark matic	۲				ngton	19b. Mailie	na Address (Street				Zin Code)
State   Stat	_	aith ar 27 is r trau					husband	1				_	
Physician / Aproximate share caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate share caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Individual Belleview Individual Bell	ע	es 1 a of He of Hem litem		20a. Method of Dispos	sition	•	20b. F						
Physician / Aproximate share caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate share caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Individual Belleview Individual Bell		Pag ment ant: I		`4 □Donation 5	Other (Specif	y)	ate	een Mou	ınt Crema	tory			
Physician / Aproximate share caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate share caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Individual Belleview Individual Bell	000	Depart Depart Mport Iny in		21. Signature of Funer	ral Service Licer	1500		M <sup>22</sup>	Name and Addre	ss of Facility liedefe	ld Funeral	Home, Inc	• Interpretation
State  St		40360		23a Parti Foter the	h rel	nlications that can	sed the deat	th. Do not ent	5500 York	Road	Baltimore	, Maryland	21212
Due to (or as a consequence of):    Due to (or as a consequence of):	J.			shock, or heart to	ailure. List only	one cause on eac	h line.	il.	er me mode or dyn	ig, such as cal	TOTAL OF PESPITATORY A	ilest,	Interval Between Onset and Death
Sequentially list conditions, gazue. Enter Underlying and the property of the	-%			disease or condition	-	a Due to (or	as a conse	TIMIA					MINUTY
Due to (or as a consequence of):    If FEMALE:   23b, Was decedent pregnant   1   1   1   1   1   1   1   1   1		Examiner		Sanuartially list condi	tions	M	YOCAN	11	faction				Minutes
Due to (or as a consequence of):    If FEMALE:   23b, Was decedent pregnant   1   1   1   1   1   1   1   1   1		모 ;	iner	if any, leading to imme cause. Enter Underlyi	adiate ang	Due to (or	as a conseq	juence of):					
FEMALE:   23b. Was decedent pregnant   10   10   10   10   10   10   10   1		and I-trans	xam	that initiated events		c	as a consec	mence of):					
FEMALE: 23b. Was decedent pregnant in the past 12 mognts?   23c. If yes, outcome of pregnancy   1   2   Fedal death   3   Ectopic pregnancy   Month   Day   Year	5	sician buria	aiE		·			,00.700 0.7.					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature	00	g phy: as the				d							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature	5	th cert lendin r use	an/N	23b. Was decedent pr					Tectopic pregnancy	,			,
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature		that the detach			int conditions	ontributing to deal	th but not res	sulting in the u	nderlying cause gry	en in Part I	23e. Did t	obacco use contribute t	o the cause of death?
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature	Ŝ	uires sign				,		<b>3</b>	, <b>,,,,</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature	5	s beer s beer s shou	ojete								24a. Was	an 24b. Were a	utopsy findings available
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature	ב ו	The la	mo								perfo	rmed? // death?	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature	<u> </u>	ertifica ector, j	0		medical					The state of the s			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature	5	dkng l h. After funer	tlon	1 Natural		(Month,	Day Year)		Wor	k?	280. Describe	now injury occurred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature	2	Atten r deat sctor: by the	ifica	3 Suicide	6 Could not be	e 28e. Place of	Injury - At h	ome, farm, str			28f. Location (	Street and Number or R	ural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature	5	s after st Dire	Certi	4   Homicide		building	, etc. (Specif	(y)			City or Tou	vn, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature		Hospi 24 hour Funera tely filla		(Check only 2	Certifying Ph	niner: On the basi	s of examina	owledge, death	n occurred at the tin vestigation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Divid B. Ley MD 6701 V. Chalus St. #5105 Towson MD 21704  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature		o the o the omple	Med		a of certifier	and manner	stated.		29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daniel B. Levy MD 6701 N. Chaus St. #5105 Towson MD 21204  State 31. Date filed (Month, Day, Year) 22. Registrar's Signature				1 thu	J 11.	MD			1)5	7169		A A	
State 31. Date filed (Month, Day, Year)  Registrar  MAY 1 1 2004  State  MAY 1 1 2004		1,2		30. Name and address	of person who	completed cause	of death (Iten	n 23a) (Type,	Print)	6.5			- 1
State 31. Date filed (Month, Day, Year)  22. Registrar's Signature		`			000		N.C	hadus St	+5105	Tow	son MD 3	12001	
11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Sta Registr				67	istrar's Signa	ature	Ne s				

	1 - For Amend Item 20	b,c, State of Ma	yland/Dena 31,5/11/20	artment of H	lealth and M Death	lental Hygie	ene 2 0	04 14959
	1. Decedent's Name (First, Middle,					2. Date of Death		3. Time of Death
Physicia /Medica	MADV A	OUTLAW				Month May 6	Day 70	(ear 12:21pM
Examine	4 5 10 44 44 44 44 44	give street and number)		4b. City, Town, o	Location of Death	1	4c. County of	Death
	Sings Hosps	tal D4 1301	Himore	Balton	ore City			NA
Funeral		. Sex 7. Age 1	(In yrs. last birthday)  Fa Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	ear)	Birthplace (State or Foreign Country)
Director	215-52-0903 Usual Residence of Decedent		53 "			MAY 19, 1	1950	VA
ylano	10a. State 10b. County		10c. City, Town or Lo	cation	<u>-</u> -			10d. Inside City Limits
the Marylan	MD MD	NA	BAT	TIMORE				1X Yes 2 No
death with the Maryland ms 23e or 28e-f show rulled at	MD  10e. Street and Number  3717 REISTERT(  11. Marital Status  1 □ Never Married 2 ☑ Married			10f. Zip Code		10g	Citizen of Wh	at Country?
ath w	3717 REISTERT	DWN ROAD		2	1215			USA
	11. Marital Status	12. Was Decedent Ev Armed Forces?	1	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
38 38 Is after 10 10 10 10 10 10 10 10 10 10 10 10 10	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	· .	I□Yes 2X No	Specify:		Specify:	AFRICAN
1215-0036 within 72 hours after death with one then "natural", or items 23a on the Weddeal Evaluation of the Medical Evalu	15. Decedent's	Education	16a. Deced	lent's Usual Occup	ation	161	o. Kind of Busin	AMERICAN Dess/lodusto/
	15. Decedent's (Specify only highest (Elementary/Secondary (0-12) 12th	grade completed)  College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	durina most of workii	ng	o. Kind of Edsi	nessindustry
N pob.	12th	0		NURSE			HOSI	PITAL
be filed of other event,	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, Mai		
Marylanc larylanc 2 should be to and Mental I is marked or is marked or	JOHN H. MCI	LEOD	7		LOUIS	SE LESAN	E	
Mar Mar 12 sh 12 sh 16 m	19a. Informant's Name/Relationship				and Number or Rura			
nore, Maryland spes 1 and 2 should be file to Health and Mental Hy it of Health and Mental Hy or other treumetic event or other treumetic event	NADIEN OUTLAW-MOO	DRE (DAUGHTEI	R) 3313 20b. Place of Dispo-	VIRGIN			ORE, MI	
Baltimore, permit Pages 1 a. Department of Hez Importent: if item any injury or othe once.	1 X Burial 2 ☐ Cremation 3		Cedar Hill	Cenetary	(e)		ltimore,	ty or Town, State Maryland OWN, MD
injury	' 4 □ Donation 5 □ Other (Special Signatural Secretary		KING MEMO	RIAL PK.  Name and Address	5/14/0			
Balt Depart Import Import any injury once.	Manalan	1/1/1/1/1/1/	//-		WII	LIE FUNER		
	25a. Part1. Enter the disease, or co	prolications that caused th	ne death. Do not ente		LMOR STREI g, such as cardiac o		MORE, M	ID 21217 Approximate
Physician	Immediate Cause (Final	ly one cause of each line.			200			Interval Between Onset and Death
/Medical	disease or condition resulting in death)	aDue to (or as a c	consequence of):	Goryap	stry			
Examiner	Sequentially list conditions	b. —			/			
7 P 1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	consequence of):					
60, be executed ician and burial-transit	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					
		Due to (or as a t	consequence or).					
6876( ificate be g physicia as the bur		d						_
P.O. BOX 6i that the death certific ad by the attending p detached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of					23d. Date o	f delivery
Geath death d for	in the past 12 months?	1□Live birth 2 ( 4□Pregnant at tin		Ectopic pregnancy Other (specify)			Month	
P.O. that the de ed by the detached	9 □ Unknown	9□ Unknown						
cords, Pwrequires that we require support that should be detailed to should be detailed to the control of the c		contributing to death but r	not resulting in the un	derlying cause give	en in Part I.	23e. Did tobacc	co use contribu	ite to the cause of death?
ords, requires een sign hould be		1/1/1/23				1 🗆 Yes	2 □ No 3 [	Probably 4 Quinknown
II Record  The law requires age to should	Consisting	Host Feil	lin			24a. Was an autopsy	24b. Wer	re autopsy findings available r to completion of cause of
The The page	Caroline !	Archythmi				performed	? dea	th? Yes 2 12 No
f Vital Rec	25. Was case referred to medical		1		26. Place of Death	(Check only one)		
of Vita Physicien: this certific		Hospital:		3□ DOA Othe	ar: 4 ☐ Nursing Hom			Specify)
Sing F	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Time of Injury	28c. Injury Work		8d. Describe how in	njury occurred	
Division of Vital Records, tel or Attending Physicien: The law requires the safter death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be Ose Blees of Ising	- At home, farm, stre		/es 2 ☐ No	Rf Location /Street	and Number	or Rural Route Number,
Div A	4 ☐ Homicide determine	building, etc. (	(Specify)	et, ractory, office		City or Town, St	ario ivumber d ate)	r Aurai Aoute Number,
Spite neral		Physician: To the best of r	my knowledge, death	occurred at the tim	e, date and place, a	nd due to the cause	a(s) and manne	er as stated
Division O  To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	(Check only 2 Medical Expone)	aminer: On the basis of ex and manner stated	camination and/or inv	estigation, in my op	inion, death occurre	d at the time, date	and place, and	due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	7100		29c. License			-	fonth, Day, Year)
	Charden	Nultat n	1.1).	D 00	56388	1	Try 7th	, 2004
10	30. Name an address of per of wh	completed cause of deat	th (Item 23a) (Type, F	Print)	, /1	1 0 - 1	111.	
	Chandre 31 Date filed (Marth San Am	sh Shilm	+ M.D.	Dine	56388 51 Hospin	tal Dy	5/tsm	Y
State Registra		32. Registrar's	o oignature	Amount :	-	V		

		riease	State of Maryla				-	_	
		1 - For State Registrar	Otate of Maryla		ertificate of			200	4 1496
<b>♦</b> (3)		Decedent's Name (First, Middle, Las	(t)				2. Date of Death		3. Time of Death
Physic		Kobert	Palme				May	6 2004	12:478
/Medi Exami		4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Dee	
		University of Mas	ruland Grospi	ital	Bar	Hmore.		N/A	
Funeral		5. Social Security Number 6. Se		s. last birthday,	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) Co	thplace (State or Foreign ountry)
Director		049-14-7101	A.M 2UF //	Yrs.			June 17	, 1926	CT
and		Usuel Residence of Decedent  10a. State 10b. County	10c. (	City, Town or L	ocation				10d. Inside City Limits
Mary! feho	ō	CT Lite	hfield		New Hartf	ord			1 <b>⊠X</b> es 2 ☐ No
the the 28a-	Director	10e, Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
3a or		19 Vickers R	oad		,	06057		USA	ŕ
iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene.  If Itam 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be neithed.	Funerai	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	dispanic Origin? (Spe an, Mexican, Puerto	ocify Yes or No-	14. Race - Ame	
after or Ite	F	1 ☐ Never Married 2X Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give				rican, etc.)	Black, Whit	
raf,	l by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	white
72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	edent's Usual Occup kind of work done	ation during most of worki d)	ng 16	b. Kind of Business	/Industry
ad within 72 hours at giene. er then "natural", or i, the Medical Exem	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.		oller		II	-1
filed wil Hygien other th		12 17. Father's Name (First, Middle, Last)	2		COLLCT	18. Mother's Name	/First Middle Ma	Hospit	car
nd 2 should be file lith and Mental Hy 27 te marked oth rtraumatic event	Be	Malcolm Palmer				Blan		Carter	
should Ind Mening Menin	မ	19a. Informant's Name/Relationship (7	(una Print)	10h Maili	ing Address (Street			City or Town, State, 2	Zin Codol
d 2 shouth and 7 to my		Laura Palmer /	**			Road, New			
permit. Pages 1 and 5 Department of Health Important: If Itam 27 eny injury or other tra		20a. Method of Disposition	20b.	Place of Disp	osition (Name of	' .	The state of the s	c. Location - City or	
ages int of t: If It		1 ☐ Burial 2 ☐ Cremation 3 🕱		_ ·	matory or other place Cemetery			Corringtor	
nit. P artme ortan injury		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			2. Name and Addre		2/200-1	iorringcor	1 01
permit. Pages 1 a Department of Her Important: If Itam eny injury or othe			Victor P. D	Cı	narles L.	Stevens	Funeral H	lome, Inc.	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de	ath. Do not en	LOUL East	FORT AVE	nue, Balt or respiratory arres	imore Mar	Approximate
-27-17-1		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	1					Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse		mal con	ne anew	ysm		3hours
Examiner			Due to (or as a corrse	equence or).					
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):					
utted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	0						
te be executed ysicien and re burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
te be e	Physician/Medical		d						
ires that the death certificate signed by the attending phy de detached for use as the	Med	IS SELVALE	V4-04-10-05-11	- 17-					
eath certifical attending phyfor use as the	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		□Ectopic pregnancy	,		23d. Date of del	,
ne deal the att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of 9☐ Unknown		Other (specify)	'		Month	Day Year
hat the de d by the letached	Phy	9 Unknown					Tour and		
es th igner	b	Part II. Other significant conditions of		•	inderlying cause giv	en in Part I.		_	the cause of death?
w require been si should b	ted	ioronary a	uttery disea	se			1 Yes	2 No 3 (2) 1 Pr	ebably 4 DUnknown
law ias b	pie	Ventrae her	nia.				24a. Was an autopsy	prior to d	topsy findings available completion of cause of
The page	Completed						performe 1 ☐ Yes 2 ☑		2 13/10
cian: ertific	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
or Attending Physician: The law requir after death. Director: After this certificate has been si in by the funeral director, page 2 should	2	1 → Yes 2 No	Hospital: 1 Inpatient 2			4   Nursing Hor		ce 6 Other (Spec	cify)
Ing P	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor		28d. Describe how	injury occurred	
tend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	201.1 10:		
lor At after d Direct	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, st cify)	reet, tactory, office	'	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıraı Houte Number,
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		200 Codifier 457 Codifier - No.	voleton. To the best of control	noviloden den	th ====================================		and divine to the	(-)	
To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Exam	ysician: To the best of my kr niner: On the basis of examin and manner stated.	nation and/or in	vestigation, in my o	pinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
o the ithin ; o the ymple	Mec	29b. Signature and title of certifier	Aile 1 h		29c. Licens	e number	29d	. Date signed (Monti	h, Day, Year)
F 3 F 8		1/4	vorsending phys	8168 cm	20	95/- 2-1	~ /	1000 1 1	20000
()		30. Name and address of person who	completed seven of death "	om 22a\ /T	Print	10029	1	1000) 6	5004
7		Manual address of person who o	completed cause of death (Ite	ਚਾਸ ∠ਤਕ) (Type, ਹੋਣ	- O-1	- a (A+A	3,200		
C+	ate	Marcia A. Cort	32. Registrar's Sign	nature 31	Baur	work hold	, - ( ) - (		
Regist		MAY 1	Afficial of Physicompleted cause of death (Itel 2004) 32. Registrar's Sign	William It	donte	9.			
			No. of the last	-	W "W"				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. Decedent's Name (First. 2 Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**25**M 2□ F Months Hours Min. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at ¥Yes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Itams 23e 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian other traumatic evant, the Medical Examiner Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 ☐ **X**o Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry othar than College (1-4or 5+) Hygiene. Name (First, Middle, Last) s 1 and 2 should be fill if Health and Mental H item 27 is marked oth Be 19a. Informant's Name/Relationship (Type, Print) (\$154cr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place, d of Disposition 20c. Location - City or Town, State ō 1 ¥Burial 2 ☐ Cremation 3 ☐ Removal from State ö 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Funeral Service License eit. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequential / list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 N Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Dath 28b. Time of 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident within 24 hours after deatl To tha Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REANANDA KANSH NAME 821 No

Registrar

DHMH 17 Rev 1/2001

KNISHNAN

NIEUTAN 37 BALTIMONE

			1 - For State Registrar	Sta			/ Depa		t of H	ealth a	and Me	ental Hygi	-	004	14962
,	Physici /Medi	al	Diran A.  4a. Facility Name (If not institution)  1. Decedent's Name (If not institution)	Pansh				4h Cin	Tours or	Location	M	2. Date of Death Month Iay 7, 2	Day 004	Year	3. Time of Death 7:10 P M
	Examir Funeral Director	er	Gilchrist Hos  5. Social Security Number  119–18–4857		7. Ag	je (in yrs. las 81			son	If Under:	24 Hrs.	8. Date of Birth (Month, Day,		1timo	re lace (State or Foreign try) York
	D	ctor	Usual Residence of Decedent  10a. State 10b. Count	y ltimore			Town or Lo					100. 15,	1922		0d. Inside City Limits 1 ☐ Yes 2 🛣 No
9	be illed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Itams 23a or 28a-1 show event, the Medicial Examination mostle, notified at	<b>Funeral Director</b>	10e. Street and Number  2 C Garston Ct  11. Marital Status  1 □ Never Married 2 ☒ Ma	12. Wa	s Decedent ned Forces? ]Yes 2   1	No		Vas Deced f Yes, spec	21030 ent of Hi ify Cubar	spanic Orig n, Mexican		ify Yes or No- lican, etc.)	Bla	e - Americ ck, White,	an Indian, etc.
21215-0036	within 72 hours ane. than "natural", (	Completed by	3 Widowed 4 Divorce  15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education	leted)	5+)	16a. Deced (Give life. L	kind of wor DO NOT us	l Occupa k done d e retired,	luring most	t of workin	g 1	Specif 6b. Kind of B	usiness/Ind	,
Maryland 2	be filed tal Hygi d othar	To Be Co	17. Father's Name (First, Middle Adom Panshouki  19a. Informant's Name/Relation	an		•	Elect			Elia	r's Name	(First, Middle, M pouzian Route Number,	aiden Suman		
	1 and 2 s tealth an tm 27 is ther trau		Naomi Panshouk  20a. Method of Disposition  1 □ Burial 2 Macremation	ian/Wif	е	20b. Plac	2 C G ce of Dispo	arsto	n Ct	. Co	ockey May 9	sville,	MD 21	030 City or To	
Baltimore,	permit. Pages. Department of I Important: If its any injury or of once.	7	4 □ Donation 5 □ Other (	5ic)nsee Mic	hael J	Crem J. Fla	atory gle	Name and Lemmo 10 W.	Address n Fu Pad	s of Facility ineral lonia	Road	e of Du	lum, M	Valle	y, Inc.
THE STATE OF THE PARTY OF THE P	Pnysician /Medical Examiner		23a. Part1. Enter the disease, a shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	that caused be on each ling.	) S+	Age					-	st,		Approximate Interval Between Onset and Death
68760,	ate be executed hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate name. Find Indignity in Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as		<i>'</i>								
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 4	es, outcome Live birth Pregnant at Unknown	2 Fetal de	eath 3	Ectopic pre					23d. Dat Mo	e of deliver	y Day Year
Ś	w requires that been signed b should be deta		Part II. Other significant condit	s me	. ((;	tus				n in Part I.		23e. Did toba			e cause of death?
Vital Record	an: The law rificate has be tor, page 2 sh	e Completed	peripher Strokes 25. Was case referred to medic		ticu	Jar	dis	e 45 s		26 Place	of Ceath /	24a. Was an autopsy performe 1 Yes 2.	ed?	Vere autoperior to com leath?	sy findings available upletion of cause of
Division of Vi	To the Hospital or Attending Physician: The I within 2 Hours after death.  To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	ation: To B	2 - 700100111	ng igation	1 ☐ Inpatie Date of Injur (Month, Day	ry 28	Outpatient  Bb. Time of Injury		Other	r: 4 □ Nur at	sing Home	5 □ Residen     d. Describe how		er ( <i>Specify,</i>	Hospia
Divis	pital or Att ours after de aral Diracte filled in by t	il Certification:	4 [] Hornicide	nined 28e.	Place of Injubuilding, etc	c. (Specify)						f. Location (Stre City or Town, d due to the cau	State)		·
	To the Hospite within 24 hours To the Funeral completely filled	Medicai	(Check only 2 Medica one)  29b. Signature and title of certifity	Examiner: On and	the basis of d manner sta	examination ited.	and/or inv	estigation, 29c.	in my opi License	nion, death number	h occurred	at the time, date	and place, a	ind due to	ay, Year)
)	8	1	30. Name and address of person		d cause de	eath (Item 23	Ba) (Type, F	Print)	2.S	كاطن	0.0	ind.	194	8,2	986
	Sta Registr		31. Date filed (Month, Day, Year	2004		ar's Signature		Spi	uks	100	WTO.	. vn (	C(2(	1/2	

Panshoykiun Diran

			For State Registrar	State of M	laryland /	Departi Certif	ment of H ficate of L	ealth and Death	d Mental Hy	giene 2	004	14963
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De	Day	Vaar	3. Time of Death
	/Medic			owman		sdorf			May	9 2	00 <sup>Year</sup>	10:25 PM
	Examir	er	4a. Facility Name (If not institution, give s	street and number	r)	41	D. City, Town, or	Location of Deville	eath		ty of Death	
_			Casey House  5. Social Security Number 6. Sex	7.4	ige (In yrs. last i	hirthday) If	Under 1 Year	VIIIE	rs 0 Data of Bi		tgome	
	Funeral Director			M 2∭2 F	84		onths Days		in. 8. Date of Bir (Month, Da Nov. 19	9, 1919	Cour	place (State or Foreign htry) Lucky
	ъ		Usual Residence of Decedent						110 1 .	, 1717	Kem	Eucky
	arylar show	_	10a. State 10b. County		10c. City, To	wn or Location					1	10d. tnside City Limits
	he M	ecto	Maryland Montgor  10e. Street and Number	nery			Gaither	sburg				1 □ Yes 2 X No
	with Ba or	급	217 Booth St. #407	7 A			10f. Zip Code	20878		10g. Citizen o United		*
	death	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. Was			(Specify Yes or No erto Rican, etc.)		ace - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Modical Existing must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces  1 1 Yes 2 1  If Yes, Give	] No	10	s, specify Cubar Yes 2∏ No	n, Mexican, Pu Specify:	erto Rican, etc.)	Spec	ack, White,	<sub>etc.</sub> Thite
21215-0036	2 hou	ted	15. Decedent's Educ	cation	1940-44	a. Decedent	's Usual Occupa	tion		16b. Kind of		
215	hin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or		(Give kind	d of work done d NOT use retired)	uring most of w	vorking	10011111001	0 0011100001111	austry
7	ed wit	Con		4	.,	H	omemake	r		Own	Home	
Maryland	ibe fill ad oth evan	Be	17. Father's Name (First, Middle, Last)  James Richard	Benge				18. Mother's N	lame (First, Middle			
Ĕ	thould id Me mark matic	ပို	19a. Informant's Name/Relationship (Type		-1 19	Ph. Mailing A	ddross (Street a		Rural Route Numb	Bowman		Codel
	nd 2 sulth ar		Merry Runsdorf Mend	,					Rockville		20853	
J.	s 1 a of Hea itam otha		20a. Method of Disposition		20b. Place	of Disposition		_	Date ay 11	20c. Location		
Ē	Page ment cant:		1 ☐ Burial 2 M Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	9 .		Cremato		2004	Be1t	svill	e. MD
Baltimore,	permit. Departi Importi any inj		21. Signature of Funeral Service License	18	M00382	22. Na Rap 933	p Funera	s of Facility al and	Cremation	n Servi	ces	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that cause	ed the death. Do							Approximate Interval Between
. 1	Physician		Immediate Cause (Final disease or condition			ial Pu	1monary	Fibros	is			Onset and Death
	/Medical Examiner		resulting in death)		s a consequenc		-					,
		7	Sequentiatly list conditions,	Due to (or a	s a consequence	e of):						
	uted d ansit	Examiner	if any, leading to immediate Cause (Disease or injury	200 10 (0. 2.	o a osmooquomo.	0 0.7.						
o,	exection and and rial-tra		that initiated events c. resulting in death) Last	Due to (or a	s a consequence	e of):						
8760,	ficate be executed physician and is the burial-transit	dlcal	d									
9	ertifica ling pl e as t	a)	IF FEMALE:									
Box	eath certific attending p	Physician/M	in the past 12 months?		e of pregnancy 2  Fetal deat at time of death		opic pregnancy				ate of delive onth	ry Day Year
o.	that the de led by the a detached f	yslo	1 ☐ Yes 2 ሺ No 9 ☐ Unknown	9 Unknown	at time of death	5 🗆 Otn	ner (specify)					·
ري. ص	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by Pł	Part II. Other significant conditions con-	tributing to death	but not resulting	in the underl	lying cause giver	n in Part I.	23e. Did to	obacco use cor	tribute to th	e cause of death?
rd	w require been sig should b	edb							1 🗆 1	Yes 2 <b>X</b> No	3 🗌 Proba	ably 4 □Unknown
Records,	has be	Completed							24a Was		Were autop	osy findings available inpletion of cause of
		Соп							perfo	rmed? 2 <b>∑</b> No	death?	
Vita	ysician: Th	Be	25. Was case referred to medical examiner?	osnital:			Othor		eath Check onl o			
ō	Phys r this ral dir	. To	1 ☐ Yes 2 📉 No	ospital: 1 ☐ Inpati 28a. Date of Inj		Outpatient 3 Time of	DOA Other	4   Nursing	Home 5 ☐ Resid			Hospice
lon	nding Pt. th. : After the funeral	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year)	Initury	Work?	es 2⊡No	Zod. Dodolibo i	iow injury occu	1160	
Division	or Attano after death Diractor: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, to. (Specify)	farm, street, f	factory, office		28f. Location (S City or Tox	Street and Num.	ber or Rural	Route Number,
ā	ital or rs afte ral Dir led in	Cert		ballaling, e	ic. (Opecity)				City of You	vii, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director.	edical	29a. Certifier 1 X Certifying Physic (Check only one) 2 Medical Examin	ician: To the best er: On the basis of and manner s	of examination a	ge, death occ ind/or investio	curred at the time gation, in my opi	e, date and pla nion, death oc	ce, and due to the courred at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
	To ti Withi To ti comp	Ě	29b. Signature and title of certifier				29c. License			29d. Date signe		
)	1		· Elfe	Re 1	70			009470		May 1	10, 20	004
	1541		30. Name and address of person who cor Eugene P. Libre M					Kenc	ington, M	D 2089	5	
	Sta	e	31. Date filed IMental Day, Various		rar's Signature	. /		, Kens	rugion, M	w 2085	, ,	
	Registr		Theolog IL IL CULIA	A The same	- 10	pp	als					

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RUSSELL,

Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or page.	m	per	3 = 6
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the itnneral director, page 2 should be detached for use as the burial-transit		Phy /M Exa	rsiciai ledica amine
<i>Y</i> \	Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	<ul> <li>To the Funaral Diractor. After this certificate has been signed by the attending physician and</li> <li>completely filled in by the funeral director, page 2 should be detached for use as the burial-transit</li> </ul>
			X

			For State Of Maryl  State Registrar	and / Depa	artment of F rtificate of	ieaith and N <i>Death</i>		giene Z	004	14965
	Physici	an	1. Decedent's Name (First, Middle, Last)			-	2. Date of De	ath Day	Year	3. Time of Death
	/Media	al	David W. Robertson  4a. Facility Name (If not institution, give street and number)		4b Ch. Town	r Location of Death	May 8,	2004		4:30am M
	Examir	ier	Greater Baltimore Medical Cent	er	Towson				ounty of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	1timor	place (State or Foreign intry)
L	Director			75 Yrs.	Mortus Days	Hours Min.	Jan. 2	0, 19	29 Mai	ryland
	fand ow		Usual Residence of Decedent  10a. State 10b. County 10c	. City, Town or Lo	cation					10d. Inside City Limits
	Mary Ff sh	tor	MD Baltimore	Luthervi	110				İ	1 ☐ Yes 2 🗓 No
	th the	Jirec	10e. Street and Number	AGDIIOT VI	10f. Zip Code			10g. Citizer	of What Cou	ntry?
	ath w	Funeral Director	817 Jamieson Road		21093				USA	
	ter de Items Iner n	nne	11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Never Married 2 ☒ Married	n U.S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,	can Indian, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Vthar then "natural", or Items 23e or 28e-f show ant. The Madical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	1	I∐Yes 21XINo	Specify:		Sp	ecify: Wh	ite
2	72 hc 'natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup	ation during most of work	ina	16b. Kind	of Business/Ir	ndustry
121	within ene. then '	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	Admini	OO NOT use retired strative	during most of working the	of	۵.	1 5 6	
2	filled Hygid Sthar ant,	e Co	17. Father's Name (First, Middle, Last)	Recear	ch & Deve	2Lopment 18. Mother's Name	(First, Middle,			cactory Co.
Maryland	should be nd Mental markad c	To Be	Lloyd Otis Robertson			Marguer:			Burry	
ar Z	2 sho and N is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Numbe	er, City or To		o Code)
	fealth m 27 her tr		Shirley Robertson/Wife			Road, Lui				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic avant. The Modical Exerciner must be ruilled at once.		122 Donat 2 Commation 3 Chamboat Ion State		sition (Name of natory or other place	3/12	/04		ion - City or T	
	artme ortani injury		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Fune 15 → 5 □ 0	22.	alley Mer . Name and Addres	ss of Facility				aryland
ñ	permit. Departr Imports any inji		Michael J. Flagie	L 10	emmon Fur O W. Pado	neral Home onia Road	Timon:	ium, N	Valley D 210	Inc. 193
			23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.				r respiratory ar	rest,	•	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		rceno	مرور				3 Mon
	Examiner		Due to (or as a con	sequence of);						
	71 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of).						
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a con-							
<b>68/6</b> 0,	rificate be executed ng physician and as the burial-transit		Sub-to-to-tas a con-	saquance (i).						
200	tificate ig phy as the	ledicai	0.	-				7		
ROX	death cer e attendir id for use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pre		Ectopic pregnancy			23d.	Date of delive	•
5	that the death cer ed by the attendir detached for use	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	of death 5	Other (specify)				Month	Day Year
7.	that the	y Ph	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use o	contribute to the	ne cause of death?
coras,	w requires that the been signed by the should be detached	ed by					1 🗆 Y	′es 2□N	o 3□Prob	ably 4 inknown
eco	> 0 0	ompieted					24a. Was a		4b. Were auto	psy findings available
Ľ	Th ate pag	Com						med?	death?	mpletion of cause of 2□ No
VII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:		Otho	26. Place of Death				
ō	Phys this ral di	7: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 □ DOA Othe 28c. Injury	4   Nursing nor	ne 5 Resid			y)
101	Attending Phir death. actor: After thi	atior	1 ☑Nateral 5 ☐ Pending (Month, Day Year 2 ☐ Accident investigation	r) Injury	Work	(? /es 2 □ No		,,		
	- 9	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office	2	8f. Location (S City or Tow	treet and Nu	umber or Rura	l Route Number,
ב	pital o	0	29a. Certifier 1 🛣 Certifying Physician: To the best of my	leadadadad						
	To tha Hospital or Atten within 24 hours after deat To the Funaral Diractor: completely filled in by the	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my leading the desired from the basis of examiner: On the basis of examiner and manner stated.	ination and/or inve	estigation, in my op	ie, date and place, a pinion, death occurre	nd due to the o	ause(s) and late and pta	manner as st ce, and due to	ated. the cause(s)
	To ti To ti comp	Ň	29b. Signature and title of certifier	)	29c. License	number	2	29d. Date sig	gned (Month,	Day, Year)
	XI		· Clarker for town		Da	5546		May	8 20	, <del>-</del>
	10,		30. Name and address of person was completed cause of death (	tem 23a) (Type, P	Crint) Ca Passer	Blod.	Berlin	10000	0) 212	39
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 1 2004  32. Pegistrar's Signary	nature 6	a Paixen	/				

04 - 3116B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RONNIE A. RICKS State of Maryland / Department of Health and Mental Hygiene UNKNOWN 04-167 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** 8, MAY 0225 A M /Medical ne (If not institution, give street and number) HOPKINS HOSPITAL 4b. City Town or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F 214-90-3026 Director Usual Residence of Decedent 10b. County State 10c. City, Town or Location 10d. Inside City Limits "natural", or itama 23a or 28a-f ahow traumatic evant, the Madical Examinar roust be notified at Yes 2 No Director CI Imor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? COX 120 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 🗌 Yes LAC 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use repred) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "na any injury or other traumatic event, It is Made once. Elementary/Secondary (0-12) College (1-4or 5+) selt 17. Father's Name (First, Middle, Last) 18. Mother's Name (Pirst, Middle, Maiden Sumame) obe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date Burial 2 Cremation 3 Removal from State -13-04 MARY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ( towell Funeral 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit o the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 ☐Live birth 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

↑ Yes 2 □ No 24a. Was an autopsy performed? certificate 1 Yes 2□ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 □ No 1 🗌 Inpatient XXER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending within 24 hours after ....
To the Funeral Director: A investigation d 5/5/04 1 🗌 Yes 2 TNo hours after death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or To 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a scales.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registra

30. Name and address of person who completed cause bedeath (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

8, 2004

HEUSONE MIKI. 31. Date filod (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

O.C.M.E

			State of Maryland / D	Department of Health and M		•	
			_ FOI	Certificate of Death		. No. 2004	14967
	Discost of		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Ella Boyd Robinson		May	09 2004	11:20 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		Mariner Health of North Arundel  5. Social Security Number 6. Sex 7. Age (In yrs. last bin	Glen Burnie  thday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne Ar	place (State or Foreign ntry)
	Director		4 T M 687 F	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y May 04 1	926 Col	MD
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits
	Maryla	e Completed by Funeral Director	Maryland Anne Arundel	Pasadena			1 ☐ Yes 2 ဩNo
	h the		10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	intry?
68760,	ath wit		2310 229th Street	21122		USA	
	er de k		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
336	urs aft		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: W	nite
2-0	72 hou		15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workir	16	b. Kind of Business/Ir	idustry
2	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. ad other then "neturel", or items 23e or 28e-f ehow event, the Medical Examinar must be notilied at		Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	.9		2.1
d 2			6 17. Father's Name (First, Middle, Last)	Homemaker 18. Mother's Name	(First, Middle, Ma	Househo	) I d
lan	should be filed nd Mental Hygi marked other imatic event, I	To Be	Melvin Holland	Glennie	e h	lalston	
lary	2 6 5	-		. Mailing Address (Street and Number or Rural			
Σ,	1 and Health Health sem 27			301 Braeburn Drive, Wa			
Jor	permit. Pages 1 a Department of Hea Importent: If item eny injury or othe once.		Durial 2 Michellation 3 Linemovalitom State	ry, crematory or other place) May		c. Location - City or T	
Ħ	permit. Pages Department of Importent: If it eny injury or o		* 4 □ Donation 5 □ Other (Specify)   Metro  21. Signature of Puneral Service Licensee	Crematory Inc.   20(	Stallin	Baltimore, Las Funera	Maryland I Home, P.A.
B	permit. Departr Importe eny inju		bund de	3111 Mountain Road,	, Pasaden	ia, MD 2112	22
760,	Physician /Medical Examiner	Be Completed by Physician/Medical Examiner	23a. Part). Enter the disease, or complications that caused the death. Do not shock, or heart failtyre. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any leading to attract the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	enlar steerchut	r respiratory arrest		Approximate Interval Between Onset and Death
	hysicien: The law requires that the death certificate be executed his certificate has been signed by the attending physicien and I director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of deliv	ery Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Monown	
			The transfer with the		24a. Was an		
			V		autopsy performe	d? prior to co	opsy findings available impletion of cause of
			25. Was case referred to medical	26. Place of Death		No 1 ☐ Yes	2 <b>50</b> No
of V		To	examiner? 1   Yes 2   SNo   Hospital: 1   Inpatient 2   EP/Out			ence 6 Other (Specify)	
uc	ding Ph h. After thi funeral	Certification;	1 Month, Day Year) Ir	Fime of njury at 28c. Injury at 2 Work?  M 1 ☐ Yes 2 ☐ No	8d. Describe how	injury occurred	
/isi	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	fica	3 Suicide 6 Could not be		8f. Location (Stree	at and Number or Run	al Route Number,
Division		Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	state)	
		Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	i, death occurred at the time, date and place, a d/or investigation, in my opinion, death occurre	ind due to the caused at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier  WM \( \rightarrow \)	29c. License number D 36958	3	Date signed (Month,	Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (  21 21 21 21 21 21 21 21 21 21 21 21 21 2	(Type, Print) 13 Hnurfold Goo	d #100	5 ocleato	MD211/3
	Sta Registi		MAY 1 1 2004	Sporte			

		1- State Registrar AMEND FIEM #1	State of Maryla					ene 2004	14968
		Decedent's Name (First, Middle, Last		11,01			2. Date of Death		3. Time of Death
Physi		ANTHONY PACILI	ANTHONY	RADCLIFF			Month 05 - 06 -	Day Year	9:40 PM
Med Exam		4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of Deat	000	4c. County of Deeth	1
Funera Directo	_	5. Social Security Number 6. Se 220 84 429  Usual Residence of Decedent	x 7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, )	(ear) 9. Birth	place (State or Foreig
e Maryland Sa-f ehow	ctor	10a. State 10b. County MD BALTIM		City, Town or Lo					10d. Inside City Limit
th with th	Funeral Director	1927 HILLSIDE	DR-		10f. Zip Code 212	207	100	g. Citizen of What Coul	ntry?
dwinin 72 hours after death with the Maryland giene. er than "natural", or frems 23a or 28a-f ehow in Madical Examiner must be notified at	Ď	11. Marital Status  1. Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Rece - Americ Black, White, Specify: BL	
within 72 ene. than "nai	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of word)	rking	State OF	MO
be filed tal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) WILBUR RADCLIF	F 163	COME	C 110/014		ne (First, Middle, Ma		MID
s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (7)	FF	510	CARGIL	A . 4	CATONSV	City or Town, State, Zip	Code) 21228
Pages nent of ant: If it		20a. Method of Disposition  1 Surial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	Place of Disposementery, crem RBVIII	natory or other place			SALTO MO	
permit. Departr Importa	Ŕ	21. Sign are of Funeral Service Licens	1	VA 51	Name and Addre	ss of Facility GREENE NATL	FUNERI PILE B	ALTO. MO	E 21229
Physiciar /Medica Examine	ı	23a. Part1. Enter the disease, or complete shock, or heart filture. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused the define cause on each line.  ACUTE M  Due to (or as a conse	yeloid	er the mode of dyin		or respiratory arres	,	Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	dical Examiner								
death certif e attending id for use a	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preging 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)	7011		23d. Date of delive Month	ery Day Year
sign d be	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use conditions.						1/	
The law ate has b page 2 sl	Completed						24a. Was an autopsy performe	prior to cor death?	psy findings available mpletion of cause of
	Be	25. Was case referred to medical examiner?	lospital:	7	_ Oth		th (Check only one)		
Attanding Physic death.  sector: After this by the funeral di	tion; To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	er: 4 \sum Nursing H  / at Yes 2 \sum No</td <td>ome 522 Residence 28d. Describe how</td> <td>ee 6 ☐Other (Specify injury occurred</td> <td>y)</td>	ome 522 Residence 28d. Describe how	ee 6 ☐Other (Specify injury occurred	y)
Dir	Certification;	3   Suicide 6   Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital or within 24 hours afte To the Funeral Direct completely filled in the formula of the formula o	edical	one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death ation and/or inv	occurred at the tin estigation, in my of	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
To the To the To the Complet	×	29b. Signature and title of certifler	then	. 140	DØQ	1		Date signed (Month, I	
X		30. Name and address of person who con YVETIE LESTIE KOISCO		m 23a) (Type, F	Brach	ay Balt	more, M	ay 10,200 aryland 2	1231
S Reais	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature					

			1 - For State Registrar	State of M	laryland / [		rtment			and M		giene Reg. No.	2001.	14969	
	Physici /Medic		1. Decedent's Name (First, Middle, Andrew Rusko								2. Date of Dea Month May	th Day 6	2004	3. Time of Death S:50 A M	
7	Examin		4a. Facility Name (If not institution,	give street and number	)		4b. City, 1	Town, or	Location o	of Death		4c. (	County of Death	1	
			700 Raynor Ave						ville				Baltin		
	Funeral Director		717-12-1824	i. Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last biri	thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Jan 9,	year) 1919	Con	place (State or Foreign intry) Virginia	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Loc	cation							10d. Inside City Limits	
	a-f sho	ctor	Maryland Balti	more		Cat	onsvi	11e						1 ☐ Yes 2 No	
	h with the	al Dire	10e. Street and Number 700 Raynor Aven	ue			10f. Zip		228			10g. Citiz	en of What Cou	_	
36	be filed within 72 hours after death with the Maryland nat Hygiene. ad other then "naturel", or items 23a or 28a-f show event, the Medical Examination at the multified at	y Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Marrie  3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces d 1 区 Yes 2 ☐ If Yes, Give Year or Dates	?   No		Vas Decede Yes, spec		spanic Ori n, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: Whi	, etc.	
2-00	72 hour	eted t	15. Decedent's (Specify only highest	Education	77 1. 1.	Deced	ent's Usua kind of wor	l Occupa	ition	t of work	ina	16b. Kin	d of Business/I	ndustry	
Maryland 21215-0036	d within giene. ar then "	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	eel W	e retired)			9	Whee Stee	•	ittsburgh	
and	should be filed within nd Mental Hygiene. marked other then imatic event, the M	Be	17. Father's Name (First, Middle, La Steve Ruskowski								is Menz	Maiden S	Sumame)		
ary	2 should and Men is marke eumatic	2	19a. Informant's Name/Relationshi		19b.	. Mailin	g Address	(Street a			al Route Numbe	r, City or	Town, State, Zi	p Code)	
	5 € 7 ±		Laura Ruskowski	(Wife)					Cato	nsv:	ille, Ma	_			
nore	Pages 1 ar nent of Hea int: If item iry or othe		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3		9	y, crem	natory or oti	her place	1 1	5k'	ate 1		c. Location - City or Town, State urel, Maryland		
Baltimore,	permit. Pages Department of Importent: If it eny injury or o		14 Donation 5 Other (Specify)  21. Signature OF uneral Service Licensee  22. Name and Address of Facility Witzke Funeral Home of Caton 1630 Edmondson Ave. Catonsvi												
8	88558														
	Physician		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition											Interval Between Onset and Death	
	/Medical Examiner		disease or condition resulting in death)	a. Due to (or a	s a consequence	of):	2400	<del>1</del> —	CCG					10 years	
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a cunsequence s	ofj.									
	ecuted and transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or o	s a consequence	-f).									
68760,	sate be executed obysician and the burial-transit	cal E		d	a consequence										
Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ed	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2  Fetal death	2□	Ectopic pre	00000000				23	3d. Date of deliv	rery	
P.O. B	at the deat by the att tached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death		Other (spe						Month	Day Year	
	uires that signed b	by	Part II. Other significant condition	s contributing to death								bacco us es 2□	1.0	the cause of death?	
Records,	e law requ has been je 2 shouk	Completed		the office				-(r			24a. Was a		24b. Were aut	opsy findings available ompletion of cause of	
al R	i: The cate ha			-							perfor	med?	death? 1 ☐ Yes	2 No	
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ⚠ No	Hospital:	ient 2 ☐ ER/Ou	tnations	3 DO	Othe	r	of Death	(Check only or		TO (0	4.1	
of		) <del>-</del>	27. Manner of Death	28a. Date of Inj (Month, D	_	ime of		Bc. Injury Work		-	28d. Describe h		Other (Speci occurred	īy)	
Division	il or Attendir after death. I Director: Al d in by the fu	icatle	2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no	t be One Place of In	njury - At home, fai	rm stre	M et factory		'es 2 □!	-	28f. Location (S	treet and	Number or Rue	al Route Number,	
Div	tal or A rs after el Direc ed in by	Certification:	4 Homicide determin	building, e	tc. (Specify)		, actory,	Omoo			City or Tow	n, State)		ar 10010 (Vallipo),	
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best reminer: On the basis and manner s	of examination and	, death d/or inv	occurred a estigation,	it the tim	e, date and inion, deat	d place, th occurr	and due to the c ed at the time, o	ause(s) a ate and p	and manner as solace, and due to	stated. o the cause(s)	
	To th within To th compl	Me	29b. Signature and little of dertifier	7			29c.	License	number		2	9d. Date	signed (Month,	Day, Year)	
	d,		12 40x (	will me				005	59914	f	4	5/6/	04		
	10		30. Name and address of person	mpleted cause of	death (Item 23a) (			se.	MD	rul	and	2	1228		
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signature		/	, .	7	-1	and				
	negistr	al	MAY 1 1 100	Metal		P	oour,	2/							

State of Maryland / Department of Health and Mental Hygiene 2.0.0.1

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	01.25	. 1	- 1	-1

			State of Maryla	Ce	rtificate of	Death	R	leg. No.	04	149/0
	Physicia		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al	Effie Rae Robinson			4. Oh. T	May 7,	2004		12:22 PM
	Examine	er "	a Facility Name (If not institution, give street and number)  6 Colonial Road				Location of Death	4c. County of		
				s. last birthday)	If Under 1 Year	Bel Ai		Harfo		and (State or Formian
	Funeral Director		- A D M OFKE	3 , Yrs.	Months Days		(Month, Day	6, 1920	Nort	ace (State or Foreign ny) h Carolina
	ith the Maryland or 28a-f show	,	Da. State 10b. County 10c. C	ity, Town or Lo	cation				10	d. Inside City Limits 1 ☐ Yes 2X No
	28a-1	ect	Maryland Harford B	el Air	10f. Zip Code		1	0g. Citizen of W	hat Countr	
	ath with 1 23s or Net be	Funeral Director	6 Colonial Road		21014			τ	JSA	
020	urs a	þ	1. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in the Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of lifty Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		- America k, White, et	
Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic evant, the Madeal	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.		pation during most of wo ed)	rking	16b. Kind of Bus		istry
7	ygien ygien it. The	2	6	Home	emaker				-lome	
an d	be fill H d oth	a 1	7. Father's Name (First, Middle, Last)				me (First, Middle, I		e)	
ž	d Men d Men narke	<u>۵</u> _	David Edward Teague				Vera 1			
Ma	d2st than 7 is n traun		9a. Informant's Name/Relationship (Type, Print)				ural Route Number		State, Zip C	lođe)
رة _	Healt Healt em 2	2	Mary Lou Bandy / Sister  a. Method of Disposition 20b.	947 F	Red Pump sition (Name of natory or other pla	Road, Be	l Air, MI	D 21014 20c. Location - C	City or Tow	n State
ē	ages ant of t: If it					Gardens		Bel Air,	•	
華	artme ortan Injur		1. Signature of Funeral Service Licensee						rary	/ Laiki
B	Dep Dep June Pune Pune Pune Pune Pune Pune Pune P		Attack a March				ome, P.A.			- J 21000
		-	3a. Pa 1. Er er the diseas , or complication; that crused the dea shock, or heart failure. List only one cau e on each line.				ad, Abing			
	Physician /Medical								C	Approximate nterval Between Onset and Death
	Examiner	r	mediate Cause (Final sease or condition sulting in death)  a. Congest and the condition of	100	reari	Fa114	ne		<u> </u>	
		Je	A++201	or as a conseq		son-			1	
	cuted nd ransit	Examiner	equentially list conditions.	or as a conseq	uence of):	004				
Ő,	be executed sician and burial-transit	Ĕ	equentially list conditions, any, leading to immediate uses. Enter Underlying ause (Disease or injury							
68760,	rtificate b	0 1 1		or as a conseq	uence of):					
9 ×	entific ding p	5	d						1	
Вох	ath c strenc for us	lan								
Ö	he de	Physiclan/	rt II. Othar significant conditions contributing to death but not res	sulting in the ur	nderlying cause given	ven in Part I.				ha causa of death?
s, P.O		by P					1 🗆 Ye	es 2⊡No ∜	3 ☐ Proba	bly 4 Unknown
Division of Vital Records,	v require been sig should t	ed					24a. Was ar	n autopsy ned?	availa	autopsy findings able prior to
Ö	law ras be	Completed						0.007#0	of de	pletion of cause ath?
E	The la	ភ្ជ					11146	5 2XXV	1 🗆 🗅	Yes 2□ No
Viti	cian: eartific ector,	<b>e</b> 2	. Was case referred to medical examiner?  Hospital:		104		th (Check only on	θ)		
ot	Physical this call dir	<u>e</u>	1 Inpatient 2	ER/Outpatien 28b. Time of		4 LI Nursing H	/ \	nce 6 Other	1-1-27	
ا ا	After funer	֓֞֜֜֜֜֜֜֜֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֡֓֓֓֡֓֓֡֓֡֓֡֓֡֓֡	1 Natural 5 Pending (Month, Day Year)	Injury	28c. Injui Wor M 1□	yai rk? Yes 2 □ No	28d. L'escribe ho	w injury occurred	a	
/isi	Attender death	⊒Ca	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h	ome, farm, stre		700 2010	28f. Location (Str	reet and Number	r o <i>r Rural P</i>	Route Number,
Ö	rs efte al Dire	Certification:	4 Homicide determined building, etc. (Special	fy)			City or Town	, State)		
	To the Hospital or Attending Physician: within 24 hours efter death.  To the Funeral Director: After this certific completely filled in by the funeral director.	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	la. Certifier (Check only one)  Cartifying Physician: To the best of my known one)  Cartifying Physician: To the best of my known one one of my known one of m	owledge, death ation and/or inv	occurred at the tir estigation, in my o	me, date end place pinion, death occu	, and due to the ca rred at the time, da	use(s) and mana ite and place, an	ner as state nd due to th	ed. ne cause(s)
	To th Withir Comp		b. Signature and title of certifier	10	29c. Licens			d. Date signed (	(Month, Da	y, Year)
	1		frame p	W	03	942)	8	5/7	7/0	24
	10	3	Name and address of person who completed cause of death (Iter. White MD 615 W. Mac.	m 23a) (Type, I	Print)	RolAn	LO	21014	,	
	State	3	Date filed (Month, Day, Year)  32 Registrar's Signary		7 600	DE HIL	-, (1)	21019		
	Pogistra	9	MAY 1 1 2004							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 Month 05/ **Physician** Frank J. Serafino 08/ 3:39 pm <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1911 Old Frederick Road **Baltimore** Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year June 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**☆**M 2□F 216-20-0041 Yrs 77 Director June MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow ?7 is marked other than "natural", or itema 23a or 28e-f abov traumatic event, the Medical Examiner must be notified at MD N/A Baltimore City XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1207 Cooksie Street 21230 United States Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? XXXYes 2 ☐ No Nav Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Navy 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXXNo white Completed by If Yes, Give Year or Dates: Specify: 44-46 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Langshoremen Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental John Serafin Mary Masloska 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent: If Item 27 is any injury or other traugonce. Frances M. Biedrzycki / Sister 1911 Old Frederick Road, BAltimore Maryland 21228 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holy Cross Cemetery May 12, 2004 Baltimore Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore MD Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Halder concer **Physician** Me fastatuo
Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. attending physicien Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe Yes 2 certificate has 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Peath funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Carolel Miller 900 Calon ave 4 mo 21229 31. Date filed (Month, Day, 32. Registrar's Signature State 1 2004 Registrar

			1- State of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health and Passage of Maryland / Department of Health Andrew of Health (No. 1974) / Department of Health (No. 1974) / Depa	Mental Hyd 11/2004,	giene 2004 Pap 2004	14972
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ath Day Yeer	3. Time of Death
	Physici /Medic		ZELDA MAE STULL	May	5, 2004	11:00 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	ו	4c. County of Death	
			Frederick Memorial Hospital Frederick  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birt	Frederi	C K place (State or Foreign
	Funeral. Director		212-14-7855 1 M 207F 90 Yrs. Months Days Hours Min.	Month Day	Years Moo	ntry)
	Maryland I show	tor	10a. State 10b. County Frederick Frederick			10d. Inside City Limits
3	n with the 3a or 28s	al Director	10e. Street and Number East Church Street 10f. Zip Code 701		10g. Citizen of What Cou	states
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the 21 is marked other than "neturelt, or Items 23a or 28a-f show other traumatic event, It a Madical Examination must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  3 Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto Year or Dates:  13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto Year or Dates:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify:	can Indian,
215-0	ithin 72 no he. han "netur Medical.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/Ir	ndustry
S	nied with Hygiene. other than		To Sephere Name (First Middle Leat)	on /First Adiabath	OWN HOME	
Maryland	z snould be n and Mental H Is marked ott aumatic ever	To Be	17. Father's Name (First, Middle, Last)  Samuel Calvin Free Lilly	1918 Middle,	Maiden Sumane)	
Mary	and 2 sho Balth and I n 27 Is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Ru  19c. Mailing Address (	ral Route Numbe	Battimore	MD 21205
Ψ,	o o == ==		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	Date 04	20c. Location - City or T	own, State  Marylah
Baltii	permit. Pag Department Important: I any injury o once.		21. Signal of Eugeral Semper finance of Signal and Address of Facility	2101.2	6 Rations	MD 2120;
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory an	COOK CONTRACTOR	Approximate Interval Between
4	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	tail	ine !	Onset and Death
	Examiner		COPD			
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
8760	physiciae the buri	dicai	d			
.O. Box 6	ine law requires that the death certain ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ □ Unknown		23d. Date of deliv Month	ery Day Year
rds, P.	quires that n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to t	he cause of death?
Records,	ine law require sate has been sig page 2 should b	Completed		24a. Was a autop: perfor	sy prior to co	opsy findings available mpletion of cause of
		Be C	25. Was case referred to medical 26. Place of Dea examiner?	th (Check only or		20.10
of V	S S S	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Resid	ence 6 Other (Specia	y)
	aing h. After fune		27. Manner of Death  1. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1	28d. Describe h	ow injury occurred	
Division	a or Attend after death. I Director: A d in by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet and Number or Rur. n, State)	al Route Number,
	or to the hospitel or attention within 24 hours after deat To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the c rred at the time, c	cause(s) and manner as s date and place, and due to	tated. the cause(s)
•	within To th compl	Me	29b. Signature and title of certifier  29c. License number	2	29d. Date signed (Month,	Dey, Year)
•	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print).	(N)	180 Thomas	Johnson Drive Md 21702
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 1 2004  32. Registrar's Signature  A Social		- 01	

		Please Type or Print i	in Black Ind	delible Ink.	Ensure All C	Copies Ar	e Legible.	
		1 - State of Mary		artment of He tificate of D			ne 2004	14973
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Lawrence C. Simms				Date of Death Month MAY	Day Year Zoo4	3. Time of Death 7:30 A M
Examir Funeral Director		4a. Fecility Neme (If not institution, give street and number)  NORTH ARUNIDEL HOSPITAL  5. Social Security Number  6. Sex  1 XM 2 F	, n yrs. last birthday) 78 Yrs.	4b. City, Town, or L GLEN BU If Under 1 Year Months Days	17. N   E 11 Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye JUNE 27,	4c. County of Deeth  A NNE A 1  9. Birth ar) 1925 Man	
aryland ehow	5	Usuel Residence of Decedent  10a. State 10b. County 10	c. City, Town or Lo					10d. Inside City Limits 1 ☑Yes 2 ☐ No
vith the Mi or 28a-f	Directo	10e. Street and Number	Baltimore	10f. Zip Code			Citizen of What Cor	
ING Z1Z130036 be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	by Funeral	3700 Clarenell Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 1 9 8 2 5 No If Yes, Give Year or Dates:		21229  Nas Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	A  14. Race - Amer Black, White  Specify:	
Callimore, Maryland 21215-0035 mil. Pages 1 and 2 should be filed within 72 hours aft ppartment of Health and Mental Hygiene. pportent: if item 27 is marked other than "natural", or yinjury or other traumatic event, tra Medical Exam KB.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired) ACTOT			. Kind of Business/l	
STYIBNG 2 should be filed nd Mental Hygi marked other matic event, I	To Be C	17. Father's Name (First, Middle, Last) Frederick W. Simms			8. Mother's Name (F) Mary France	ces Jaco	bs	
Ore, Maryla es 1 and 2 should of Health and Mer filtem 27 ie marke		t Buriel 2 Eksemation 2 DRamoval from State	3700 20b. Place of Dispo cemetery, cren	Clarenell sition (Name of natory or other place)	Date	altimore	MD 212 Location - City or T	229 Town, State
Baltimor permit. Pages Department of Importent: if it any injury or o		21. Signature Finance Service Lip Asse	Ĉ	ematory In remation 5 99 Frederi	of Facility of	MD, Inc	ltimore, ore, MD	MD 21228
Physician /Medical Examiner e penius and penius remail rem	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the cause of the cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the cause).	onsequence of):  Aic Cf onsequence of).	er the mode of dying,	such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
the death certificate by the attending physic	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
- E 5 6	b	Part II. Other significant conditions contributing to death but no Rewal Failure			in Part I.			the cause of death?
	Completed	Chronic OBSTRUCKIE P	lel mona	Diense		24a. Was en autopsy performed 1 ☐ Yes 20€	prior to co	opsy findings available ompletion of cause of 2 No
Phys ral di	ation: To Be	25. Was case referred to medical examiner?  1	2 ER/Outpation 28b. Time of Injury	t 3 DOA Other.  28c. Injury a Work?	4   Idursing Home			ify)
DIVISION pital or Attending urs after death. sral Director: Aftei	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury-building, etc. (\$	Specify)			City or Town, St		
DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of m 2 Medical Examiner: On the basis of examiner stated.  29b. Signature and title of certifier	amination and/or inv	r occurred at the time restigation, in my opir 29c. License i	nion, death occurred a	it the time, date	e(s) and manner as and place, and due Date signed (Month	to the cause(s)
(h)		Hey Franci MP  30. Name and address of person who completed cause of death			17415	N	may 8,	7004
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's  32. Registrar's		boots!				
DHMH 17 Rev 1/2	2001	1971 1 2004	1	Maria				

**ORIGINAL** 

			1 - For State Registrar	State of M	aryland / De	partment ertificate			nd Mer		0.0	104	14974		
	Physici		1. Decedent's Name (First, Middle, Last Howard Lee Scott							Date of Death Month PRIL	Day	Year	3. Time of Death		
	/Medic Examir		4a. Facility Name (If not institution, give	<u> </u>				ocation of		PRIL	4c. Count	y of Death	11:20A.		
	Funeral		14 MIDWAY AVE 5. Social Security Number 6. Se		ge (In yrs. last birthd	ay) If Under		If Under 2		Date of Birth	HOWAR	9. Birth	place (State or Foreign		
	Director		217-30-0791	ØM 2□F	65 Yrs	Months	Days	Hours	Min.	CT 26,	1938	Wasi	nington DC		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City Limits		
	Maryl -f sho	to	Maryland Howard		Laurel								1 ☐ Yes 2 XNo		
	or 288	Director	10e. Street and Number			10f. Zip	Code	-		10	g. Citizen of	What Cou	ntry?		
	ath wi	ral	14 Midway Avenue			207					USA				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Evaria at must be invitted at ance.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 V If Yes, Give Year or Dates:	?	3. Was Deced If Yes, spec	fy Cuban	panic Origi , Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- in, etc.)		ice - Americ ack, White, ify:			
9	2 hou	ted t	15. Decedent's Edu	cation	16a. De	cedent's Usua	Occupat	ion		1	6b. Kind of B				
215	thin 7.	Completed	(Specify only highest grad	College (1-4or	E.\	ive kind of won e. DO NOT us als	k done du e retired)	ring most o	of working		) +				
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Maryland 21215-0036	d be fi	) Be	17. Father's Name (First, Middle, Last) Howard Lee Scott,	Sr						Name (First, Middle, Maiden Sumame) Lnia Newman					
ary	shoul nd Me mark	၉	19a. Informant's Name/Relationship (T)		19b. M	ailing Address	(Street an				City or Town	, State, Zip	Code)		
	and 2 salth a n 27 ls		Linda Nicholson/S	ister	1 5	School	House	e Lan	e No	orth Ea	ast, M	D 21	.901		
Baltimore,	ges 1 t of He If itan or oth		20a. Method of Disposition  1 Burial 2 Tremation 3 DF	Removal from State	1	rematory or ot	her place)	- 1	Date		Oc. Location				
Itim	it. Paritmen rtant: njury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Lipens		Metro (		_	,	5-7 <b>-</b> 04		Baltim	ore,	MD		
Ba	Depar Impo		) Iroman	i Soci	iety o Road	of MD,	Inc. imore	MD	21228						
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused	d the death. Do not							, 111	Approximate Interval Between		
	Pnysician	7 TV	Immediate Cause (Final disease or condition	Hyperi	Lensive Grands a consequence of):	Hero.	scle	no to	'c Ca	rdie	escul	ar	Onset and Death		
	/Medical Examiner		resulting in death)	ue to (or as	a consequence of):					dis	168C				
	NEG 1	er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	മ വാദാക്യവരുന്നു വീദ്ര.							-	=======================================		
	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c											
60,	be exe cian a burial-	al Ex	resulting in death) Last	Due to (or as	a consequence of):										
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ŏ	death certificate be executed e attending physician and of for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pre					23d. Da	ate of delive	эгу		
O. B	he deat the atte	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant a 9☐Unknown		5 ☐ Other (spe					Mo	onth	Day Year		
٣	The law requires that the de ate has been signed by the a page 2 should be detached	by Ph	Part II. Other significant conditions co	ntributing to death b	out not resulting in th	e underlying ca	use given	in Part I.		23e. Did toba	icco use con	tribute to tl	he cause of death?		
ecords	equires an signi	ed b							_	1 🗌 Yes	2 🗆 No	3 Prob	pably 4 🗆 Unknown		
eco	e law requ has been je 2 shouli	Completed								24a. Was an autopsy	24b.	Were auto	psy findings available mpletion of cause of		
E R		Con								performe	ad? □ No	death?	2 No		
Vital	Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner?	lospital:			Other			eck only one,					
of		H 1	1 ☐ Yes 2 ☐ No  27. Magner of Death	1 ☐ Inpatie	iry 28b. Time	of 28	c. Injury a	4 □ Nurs		5 Residen		her <i>(Specif</i> ) rred	SCHNE		
ion	Attanding I death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Inju	М	Work? 1 ☐ Ye	s 2 □ No	0						
Division	ire n b	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	jury - At home, farm, c. <i>(Specify)</i>	street, factory,	office		28f. I	Location (Stre City or Town,	et and Numb State)	ber or Rura	il Route Number,		
	Hospital of hours a Funeral District filled is		29a. Certifier 1 ☐ Certifying Phy	sician: To the best	of my knowledge, de	eath occurred a	t the time	date and	place and o	due to the cau	se(s) and m	annor as s	tated		
	Hos 1 24 h 10 Fun	Medical	(Check only 2 Medicel Exemi	ner: On the basis o and manner st	f examination and/o	investigation,	in my opir	nion, death	occurred at	the time, dat	e and place,	and due to	the cause(s)		
	To the Hospital within 24 hours a To the Funeral D completely filled it	M	29b. Signature and title of certifier		10 -	29c.	License r	number		290	d. Date signe	d (Month,	Day, Year)		
	$\sim$		1 takin	MOST	J?		O.C	.M.E.		MA.	Y 1,20	04			
	1		30. Name and address of person who co	empleted cause of	leath (Item 23a) (Typ			a.	. –						
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature			stree	et, Ba	Ltimor	e, Mar	yland	1 21201		
	Registr		MAY 1 1 2004	Sen	- B	don s	-								

To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: A

> State Registrar

MAY 1 1 2004 DHMH 17 Rev 1/200

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cur e of death (Item 23a) (Type, Print)

**ORIGINAL** 

A2. Registrar's Signature

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

MAY

7, 2004

State of Maryland / Department of Health and Mental Hygiene 🥎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 11:30 ам **Physician** William Franklin Shaffer Мау 10. 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Upperco 16526 Trenton Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Jan 7, 192 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1₩ 2□ F Maryland Director 216-16-9362 83 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Intern 27 is marked other than "natural", or items 23s or 28e-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Medical Exactmential be notified at Upperco 1 ☐ Yes 2 X No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21155 16526 Trenton Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Btack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white IIWW 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Etementary/Secondary (0-12) College (1-4or 5+) Equipment Operator Highway Dept. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Herbert Ellsworth Shaffer Margaret Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elaine Sprinkle, daughter 4004 Carrollton Road, Upperco, MD 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Importent: If eny injury or once. Christ Lutheran Cem. 05/13/2004 Upperco, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Foneral Service Licensee Eline Funeral Home 934 South Main St, Hampstead, MD 21074 Approximate Interval Between Onset and Death Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final COPD **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760 the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death Month Day Year jo in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 **(x**) es 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 28 No page. 1 Yes 1 ☐ Yes 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 11/29 serles do 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Deogracias Faustino, 4111 L. Beckleysville Road, Hampstead, MD 21074 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2004

ORIGINAL

State Registrar

31. Date filed (Month, Day, Year,

ANA RUBIO, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ooth

111 Penn Street, Baltimore, Maryland 21201

	1	For State Registrar	State of Marylan	d / Departn		lealth a	-		2004 149
Physicia /Medic Examin Funeral Director	al	5. Social Security Number 6. Sex	etreet and number)	last birthday) If L	City, Town, or	Location of  If Under 2  Hours	_	Day 4c. C	3. Time of Death Tils P  country of Death  n/a  9. Birthplace (State or Foreit Country)  Maryland
D .	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimor		y, Town or Location					10d. Inside City Limit
with the a or 28	Director	10e. Street and Number 5820 Oakland Rd.			of, Zip Code 21227				en of What Country? .ted States
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1	If Yes	Decedent of H , specify Cuba 'es 2 🔯 No	ispanic Orig an, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)		4. Race - American Indian, Black, White, etc. Specify: White
vithin 72 hou ne. hen "naturi e Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	life. DO N	Usual Occup of work done of OT use retired	during most	of working		d of Business/Industry
d be filed wental Hygier Ked other to	To Be Col	17. Father's Name (First, Middle, Last)  Albert Miller	4	Nurse			's Name (First, Middle	e, Maiden S	lealth Care
should and Men marke	1	19a. Informant's Name/Relationship (Ty		1		and Number	or Rural Route Num	ber, City or	Town, State, Zip Code)
and 2 fealth a m 27 io her trat		Ralph Shiflett / h		5820 Oa		Rd. Ar	butus, Man		21227 ation - City or Town, State
Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition  1 □XBurial 2 □ Cremation 3 □ F  1 □ Donation 5 □ Other (Spedify)		emetery, cremator	v or other plac	ia1 0.	5/07/2004		idge, Maryland
permit. P Departme Importan any injur		21. Signatur Funeral Service Licens	ве	22. Nar	me and Addre	ss of Facility	Ambrose F	unera	1 Home, Inc. s, Maryland 2122
Physician /Medical Examiner	ılner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Auc or as a consequence to force a consequ	elic f	Resp Lat	eiral teral	Ty Fou	Ivre zosi	Approximate Interval Between Onset and Death Onset and Death
cate be executed shysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of);					
he death certificate r the attending physi ched for use as the b	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopMs? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 □Ecto	opic pregnancy er (specify)	/		23	8d. Date of delivery Month Day Year
requires that the de seen signed by the a hould be detached f	d by Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the under	ying cause giv	en in Part I.		tobacco use	e contribute to the cause of death?
The faw ate has b page 2 s	Completed						24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 2 100
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To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification; To	27. Manner of Death  1 Matural 2 Accident 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		y at	28d. Describe	how injury	
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To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Exemination Medical Exemination (Check only one) 29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	ation and/or investig	29c. Licens	se number	. 1		signed (Month, Day, Year)
m		30. Name and audress of person who c	omplete cause of death (Item	n 23a) (Type, Print		2506		JV\ au	14 2004
Sta	ate	SOHAIR VOUS 31. Date filed (Month, Day, Fear)	1 7 90 00 32. Registrar's Signa	ature 14 V		Bal	Timore	//W,	1) 21229

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month CATHERINE TERESA SCHEURICH 11:15 A 2004 /Medical May 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Manorcare, Ruxton Towson 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Hours 1□M 2∏F Director <u>212-07-8054</u> 87 July 15. 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral, or items 23a or 28a-f ahow Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Co Annapolis 10f. Zip Code 10g. Citizen of What Country? 104 Steffey Drive 21403 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after annot of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, it a Medical Exturing Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TNo If Yes, Give X Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary IRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Eugene Charles Scheurich Frances Bahlman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Steffey Drive, Anna olis, Maryland 21403 M. Catherine Butler (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Holy Cross Cemetery 5/11/2004 Prooklyn, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Vicens Mitchell-Wiedefeld Funeral Home, Inc. Karly Lauson 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** exelvovescu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). law requires that the death certificate be executed detached for use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perfor 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 7 this funeral Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of After t 28d. Describe how injury occurred Hospital or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 2)-12849 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) LER Dr. Tonson, MD. ZIZOL H. GH12A 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 14980 1 - For State Registrate Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** 2004 Mary Celia Spiegel 8:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 4, 1918 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 H Months Days Hours Міп. New York 85 054-14-4804 **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic evant, the Medical Exeminer must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ò 21212 U.S.A. or Itams 23a 6401 N. Charles Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: White 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is 1 and 2 should be filed within in the sith and Mental Hyglene. Itam 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Religious School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ဂ Spiegel Celia August 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 N. Charles St. Baltimore, Maryland 21212 Bernice Feilinger SSND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ital
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State ☐Donation 5 ☐ Other (Specify) Villa Maria Cemetery 5/11/04 Glen Arm, Maryland gnature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of jury that initiated events Due to (or as a consequence of): Examine that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2X No detached the 9□ Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ PULMONARY FIBROSIS 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The performed? certificate 2X No 1 ☐ Yes 2 ☐ No 1 🗌 Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient P 1 ☐ Yes 2X No 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1. X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month, Day, Year) D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM, 7601 OSLER DRIVE. TOWSON. MARYLAND 21204 M. D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

is Smith		Please Type or Print in Black In		•	_	
		State of Maryland / Dep	artment of Health and N <i>rtificate of Death</i>		2004	14981
		Registrar  1. Decedent's Name (First, Middle, Last)	Tuncate of Death	2. Date of Death	g. No.	3. Time of Death
Physic		JOCKIS HUSANI SMITH		May 06,	Day Year	2305P. M
/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2	4c. County of Death	
		Johns Hopkins Hospital	Baltimore		NA	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
Director		219-08-4389		JUNE 2,	1984	MD
nyland thow	_	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
Ba-fa	Director		IMORE			1 X Yes 2 □ No
with to		1706 N. DEGLERAD CONTROL	10f. Zip Code	10	g. Citizen of What Cou	intry?
leath ns 23	Funeral	1706 N. REGISTER STREET  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21213 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Ameri	ican Indian,
or Iter	F	1 TX Never Married 2 ☐ Married 1 ☐ Yes 2 TX No	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White AFR	, etc. LCAN
21215-0036  d within 72 hours after death with the Maryland giene. arthan "natural", or Items 23a or 28a-f ahow it ma Maricel Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:			AMI	ERICAN
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Maryland d 2 should be file th and Mental Hy t7 Is marked oths traumatic avant,			ing Address (Street and Number or Run			p Code)
Heal Heal em :		CALVIN K. SMITH (FATHER) 1442  20a. Method of Disposition 20b. Place of Dispo		LTIMORE, Date 20	MD 21230  Oc. Location - City or T	own, State
Pages nent of int: If it		Manual 2 Community 3 Manual III State	l l	2 2004	LANSDOWNE	MD
Baltimore, permit. Pages 1 a Department of Hea Important: If item any injury or otha			2. Name and Address of Facility WY			
ದ ಕೃತ್ವಕ್ಷ			38 N. GILMOR STREE			1217
2 **		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		or respiratory arres	st,	Approximate Interval Between Onset and Death
Pnysician /Medical			that Would			
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P.O. BOX nat the death cer by the attendir etached for use	sicia	in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death 5[	□Ectopic pregnancy □ Other (specify)	-	Month	Day Year
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ds,	d by	Fait II. Other significant conditions commodify to death but not resulting in the t	andenying cause given in Fatti.		2 □ No 3 □ Pro	1.4
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Re The la te has age 2	omp			autopsy performe	prior to co ed? death?	ompletion of cause of
ian:	Be C	25. Was case referred to medical examiner?	26. Place of Deat	Check only one		20110
of V hysic this ce	은	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatie	The second secon		ce 6 □Other (Speci	fy)
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Division of Vital for Attending Physician: I after death. Director: After this certificat	fical	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, st		28f. Location (Stre	et and Number or Run	al Route Number,
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier (Check only (Check only 2 Medical Exeminer: On the basis of examination and/or in				
tha h	Medical	one) and manner stated.  29b. Signature and tille of certifier	29c. License number		d. Date signed (Month,	
T O O		That UK	O.C.M.E.		ay 07, 200	
001		30. Name and address of person who completed course of death (Item 23a) (Type	Print) 111 Pon- Ob-	+ D=3+*	mana 1/	land 21201
12	)	MITTO DORE MIKING	Print) 111 Penn Stree	L, Bdltl	more, Mary	זמווט 21201
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DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		rtment of H			ene g. No. 2004	14982
	Physicia		1. Decedent's Name (First, Middle, Last)	llen Sandli	in			2. Date of Death Month May 10	Day Year	3. Time of Death 5:50 A M
>	/Medic Examin	100	4a. Facility Name (If not institution, give st 5977 2nd Street	reet and number)		I	Location of Death		4c. County of Death Anne Ar	unde1
	Funeral Director		040-22-9963	7. Age (In yrs. Ia 72	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEPT 13		plece (State or Foreign ntry) necticut
	72 hours after death with the Maryland natural; or liama 23e or 28e-1 show dical Examiner must be nutiliad at	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Anne Arun  10e. Street and Number		, Town or Lo	cation		16	og, Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
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yland	2 should be filed within and Mental Hygiene. is marked other than sumatic event, the M	To Be (	17. Father's Name (First, Middle, Last)  Albert Sandlin	Drint)	10h Mailie	an Addrage (Street	Emma Ge	e (First, Middle, Meorgia Su		n Code)
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a consequ	uence of):	er the mode of dyin				Approximate Interval Between Onset and Death
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of	fing After fune	tion: To	1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur	4 🗀 Nuising n		nce 6 □Other (Spec w injury occurred	ity)
Division	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
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	To th To th compl	Me	29b. Signature and title of certifier	11 -		29c. Licens		2:	9d. Date signed (Month	
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	Sta Regist	ate rar	31. Date filed (Month! Day Year) MAY 1 1 2004	32. Registrar's Signa	Ture,	South				

			1 - For State Registrar AMPND TIPM #20	State of M	1aryland <b>0831</b> 5/1	/ Depa	artmen <b>#ificat</b> e	t of H e of L	ealth a	and M		giene	2004	14983
>	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Las ERALDINE  4a. Fecility Name (If not institution, give	street and number	COTT			<u>-</u> -	Location of		2. Date of De Month	ODay	2004 ounty of Death	3. Time of Death 2:30 A M
	Funeral Director		5. Social Security Number 6. S 216-20-6929	/.	ige (In yrs. Ias	TER t birthday) Yrs.	RAG If Under Months		If Under Hours		8. Date of Bir (Month, Da 06-04-		Cou	place (State or Foreign ntry) t Virginia
	e Maryland le-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  NA			Town or Lo								10d. Inside City Limits 1 XYes 2 □ No
	h with the 23e or 28 st be no	Funeral Director	10e. Street and Number 1901 Talbot Street				10f. Zip	Code 21207	7			10g. Citizer	of What Cou	ntry?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23e or 28e-f show other treumatic event, the Madical Exameter rotation be notified at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	? <b>L</b> No		Vas Deced Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto (	cify Yes or No Rican, etc.)		Race - Americ Black, White, Decify: Blac	etc.
Maryland 21215-0036	filed within 72 h Hygiene. Ather then "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12		5+)	16a. Deced (Give life. L Teach	kind of wor OO NOT us	l Occupa k done d e retired)	ition luring most	t of workir			of Business/In	,
yland	should be file and Mental Hy s marked othe umatic event,	Be	17. Father's Name <i>(First, Middl</i> e, <i>Last)</i> Sager Jeter						Coney	y Jet				
	1 and 2 sho Health and tem 27 is ma other treuma		19a. Informant's Name/Relationship (7) Dwayne G. Scott/	-		1901	Talbo	t St	. Bal	lto,	MD 212		own, State, Zip	Code)
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item eny injury or othe once.		20a. Method of Disposition  135 Surnat 2 ☐ Cremation 3 ☐  14 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen	EMICMEMENI			Fores . Name and	t Ve	t. 5- s of Facility	-13-C		BALIC Owing	s Mill	s, MD
60,	Physician /Medical Examiner	Ical Examiner	23a Part1. Enter the disease, or compand to the control of the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chase United the cause in the cause in the cause cause in the cause cause. Enter Underlying Chase United the cause in the cause i	a	ad the death. line.  S a consequent a conseq	Do not enter  5  nce of):	TTE F	uner	al Ho	ome 6	r respiratory ai	ilmor	St. Ba	1 to MD Approximate Interval Between Onset and Death
.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ONo 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3 🗆	Ectopic pre Other (spe					23d	. Date of delive Month	ery Day Year
Δ.	w requires that been signed b should be deta	by	Part II. Other significant conditions of		but not resultin		derlying ca	luse give	n in Part I.			obacco use		ne cause of death?
Vital Records,	: The law racate has be page 2 sh.	Completed									24a. Was autop perfo: 1 \( \text{Yes} \)		prior to cor death?	psy findings available mpletion of cause of 2 No
Division of Vita	Hospitel or Attending Physicien: The Abours after death. Funerel Director: After this certificate telly filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner?  1	Hospital: 1 Appat  28a. Date of Inj (Month, Date of Institution of	ury 28 ay Year)	VOutpatient 3b. Time of Injury a, farm, stre	28 M	Cther  Ct	r. 4 🗆 Nur	rsing Hom 2 No	(Check only one 5 Resided Reserved Resided Reserved Reser	lence 6 one of the following of the foll	curred	y) I Route Number,
1	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical Ce	29a. Certifier 1 Certifying Ph. (Check only one) 2 Medical Exam	rsician: To the best iner: On the basis of and manner s	of examination	odge, death and/or inv	occurred a estigation,	at the time in my opi	a, date and inion, deat	d place, a	nd due to the o	cause(s) and date and pla	d manner as st ce, and due to	rated. the cause(s)
•	To the within 2 To the complet	Me	29b. Signature and title of certifier	PNYSIC					number 178		U	PAN	gned (Month,	2004.
	18		AVVERABAI		HAO	ris H	Print)	401	W 0 L 7	EST	AT ROF	MAL	ed Do	11133.
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1	32. Regist	rar's Signature	, St	Som	ne	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) M **Physician** 2004 /Medical 4c. County of Deet 4b. City, Town, or Location of Death 4a. Fechity Name (If not institution, give street and number) Examiner art 8. Date of Birth Month, Dey, 9. Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Hours -28-360 1 □ M 2 🗸 F 2 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Itams 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number na 0 Funeral  $1\alpha$ 12. Was Decedent Ever in U.S. Affined Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Maryland 21215-0036 naturel', or Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental h 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bro herl permit. Pages 1 and 2.
Department of Health at Important: If Item 27 is eny injury or other trau-20b. Place of Disposition (Name of cemptery, crematory or other place) Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2004 -1017 4 ☐ Donation 5 ☐ Other (Specify) 23. Name and Address of Facility 21. Signature of Funeral Service Licensee Home Joseph Ave. 2222 orth Approximate Interval Between Onset and Death 23a. Part I Enter the disease, or complications that caused the death. Do of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition recumoner **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause of injury Due to (or as a consequence of) Examiner the attending physician and the for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Year Month Day 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by page 2 should be 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No has certificate 1 Yes or Attending Physician: filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural Division 5 Pending after death. 1 Tyes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 15700 B completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 1 2004

DHMH 17 Rev 1/2001

Registrar

				For State Registrar		Stat	te of M	arylan		irtment of F	lealth and l	Mental Hy	giene (	004	14985
		Physici	an	1. Decedent's Name (First, A	iddle, Las HENRY	•		т.		SACk	/s	2. Date of De Month	•ath Day 2004	Year	3. Time of Death 5:15 P M
	>	/Medic		4a. Facility Name (If not insti			nd number)				or Location of Deat			nty of Death	
		Examin	er	HOSPICE OF BA	-				CENTER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	TOWSON			BALTI	
		Funeral		5. Social Security Number	6. Se	ЭX	7. Ag	ө (In yrs. i	last birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, Di FEB.1			nplace (State or Foreign untry)
À		Director		212-26-8888		X M 2		74	Yrs.			FEB.1	,1930		MD
Spa		land		Usual Residence of Deceder  10a. State 10b. Co	_			10c. City	y, Town or Lo	cation					10d. Inside City Limits
5		Mary F sh	tor	<sup>®</sup> MD	HAR	FORD	ı		ABERD	DEEN					1 X Yes 2 □ No
130		n 72 hours after death with the Marylar "naturel", or Items 23s or 28e-f show solical Examinar must be notified at	Funeral Director	10e. Street and Number				.1		10f. Zip Code			10g. Citizen o	f What Cou	untry?
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(3)		er dez	une	11. Marital Status		Am	ed Forces?		S. 13. V	Vas Decedent of F Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or Note to Rican, etc.)	o- 14. R:	ace - Amer lack, White	rican Indian, o, etc.
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- 20	218	thin 7	Completed	(Specify only h Elementary/Secondary (0-			ege (1-4or	5+)	lite. L	OO NOT use retire	during most of wo d)	rking			
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RE <	afyland 21215-0036	a la b	To Be	17. Father's Name (First, Mic SAMUEL	iule, Last)				SACKS	i	SADIE		r, maideri Surri		SENFELD
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en	<u>2</u>			MYRNA SACKS	/ WI	FE		20h B	_	NORTHGAT sition (Name of	E ROAD -	ABERDE	EN MD		
重工	altimore	Pages 1 and neut of Healint: If item 2 iry or other		20a. Method of Disposition 1 X Burial 2 ☐ Crema			from State	C	emetery, cren	natory or other pla	<sup>ce)</sup> TERY 5/1			ΓIMORE	
57	Ħ	F @ J		*4 □Donation 5 □Oth 21. Signature of Funeral/Se				DIV			ess of Facility SO				
SAC165,	Ba	permit. Departi Import. any Inj once.		1/0	y X						ERSTOWN				
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	₹ 	nyeici nis cer direc	To B	examiner? 1 ☐ Yes 2 No		Hospital:	1 ☐ Inpati	ent 2 🗆	ER/Outpatien	3 □ DOA Ott	ner: 4 \sum Nursing F	Home 5 ☐ Res	idence 6 XO	ther (Spec	ity) - ospice
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A	isio	ttendi death. tor: /	icati	3 ☐ Suicide 6 ☐ C	vestigation ould not be		Place of In	iuny - At ho	ome form etre	M 1 =	Yes 2 □No	28f Location	Street and Nur	nher or Ru	ral Route Number.
	Div	el or A s after l Direc d in by	Certification:	4  Homicide di	etermined	206.	building, e	c. (Specify	y)	set, ractory, omce			wn, State)	1001 01 1101	ai riodio railibol,
		To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this cartification is completely filled in by the funeral director, is completely filled in by the funeral director, is	edicai (	29a. Certifier 1 Certifier (Check only one)	tifying Ph lical Exaπ	niner: On	To the best the basis of manner st	f examina	wledge, death tion and/or inv	occurred at the ti restigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and r date and place	nanner as	stated. to the cause(s)
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		13		30. Name and address of pe					23a) (Type,	Print)	205 P	201	***	. , > .	Ce
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DHMH 17 Rev 1/2001

Registrar

2004

cm State of Maryland / Department of Health and Mental Hygiene 1- For Late unpend item#23a,27,28a-f,PER ME,C83152-1177-2006 of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NAYNE Month TYNES April 30 2004 12:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3720 Overview Road Baltimore N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 212-86-8663 Director Yrs MD Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 No BALTIMORE Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3720 DVERVIEW items 23a KOA D 21215 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any nijury or other traumatic event. The Medical Exercises must once. Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Yes 2 No Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EUGENE WATSON ANGIE TYNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3720 OVERVIEW ROAD EUGENE WATSON - FATHER BAHO. MD. 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. MetMod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-7-04 Balto MD SACRED HEARTOFJESUS \*4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Fun Suc P.A. Michael Ziglier Fun Suc P.A. P.O. Box 67338 BAlto. MD. 21215 21. Signature of Faneral Sea hae lier 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Narcotic Intoxication Physician disease or condition resulting in death) /Medical Due to (or au consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iripiry that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been signated by 1 □ Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate Yes 2 🗆 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1XYes 2 ☐ No Certification: To 4□ Nursing Home 5□ Residence 6X□Other (Specify) at scene his funeral 28a. Date of Injury Out (Month, Day Year) 4/30/04 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After fouredy 12:16 s after dec. 1 Natural 5 Pending unknown 1 ☐ Yes 2 📉 No РМ investigation 2 Accident 6 X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found at home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3720 Overview Rd., Baltimore, MD filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2 Munice O.C.M.E. May 01, 2004 ne and address of person who completed cause of death (Item 23a) (Type, Print) MANYDMM KOR EL 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 1 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AM 11:56 1 HOMAS HURMAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner lanc tim If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow other traumatic event, the Medical Examiner mout be nutified at 1 XYes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "natural", or Itel eny injury or other traumatic event. the Medical Exemp 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname (First, Middle. Be 19b. Mailing Address (Street and Number 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ¹ 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee once 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician H377+MATTOUS /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Certification: To Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe 2□ No 1 ☐ Yes 2 PNo 1 Tyes To the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 U-10 2 PER/Outpatient 1 Inpatient 1 Tyes 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Name and address (I person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

(Month, Day, Year) Y 1 1 2004

		•	For State Registrar	State of M	larylan		artmen rtificat					giene Reg. No.	2001	1498	Q
	Pĥysici		1. Decedent's Name (First, Middle, L GREGORY TH	•							2. Date of De Month	Day	Year 2004	3. Time of Death	м
>	/Medic Examin		4a. Facility Name (If not institution, g Saint Joseph			er	4b. City,	Town, or	Location o	of Death			County of Dea		
	Funeral Director		5. Social Security Number 216-86-4003  Usual Residence of Decedent	Sex 7. A 1 X M 2 □ F	ge (In yrs. 1	last birthday, Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 0 1 - 1 )	th ly, Yea <i>r)</i> 2 – 66	9. Bi C B.	thplace (State or Forei ountry) ALTO .	gn
	Maryland a-f show	tor	10a. State 10b. County MD.		10c. City	y, Town or L 'ARKV'	cation LLE	MD.						10d. Inside City Limit	
	th with the 23e or 28 ust be not	al Director	10e. Street and Number 7605 HILLE	NDALE RD	APT	. A	10f. Zip 21	234				10g. Citiz	U.S.		
9800	d within 72 hours after death with the Maryland jiele. Then "naturel", or Items 23e or 28es's show The Modical Examiner mat be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 Fi If Yes, Give Year or Dates	?  No	- 1	Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spe 1, Puerto l	city Yes or No Rican, etc.)		4. Race - Am Black, Whi Specify: BLA	te, etc.	
Maryland 21215-0036	f within jiene. r then "	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 1 2		5+)	(Give	dent's Usua kind of wol DO NOT us STRUC	rk done d se retired	luring mosi )	t of worki	ng		of Business	,	
land	2 should be filed vand Mental Hygie is marked other is eumatic event, II	To Be C	17. Father's Name (First, Middle, La. TONY JONES	st)							(First, Middle, THOM		Sumame)		
	5 € Z ±		19a. Informant's Name/Relationship JOANN LEE	(Type, Print)		760	)5 ні	LLE			APT	-	Town, State,	Zip Code)	
Baltimore,	0 0		20a. Method of Disposition  1    Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	cify)	20b. P	lace of Dispo emakery, cre	PARK°	"CEM	1	05-1	1 4 - 0 4		RYLANI		
Ball	permit. Pag Department importent: h any injury o		21. Signature of Funeral Service Lic	Howel	RX	L	600	W	38,01	YH	Well gh. B	all	meral.	2007	1
	Physician /Medical		23a. Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. LYMPHC	line. CYTI	C LE			g, such as	cardiac	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
(C) (C) (C) (C) (C) (C) (C) (C) (C) (C)	cate be executed by physician and physician and sthe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b									11 11 11		
P.O. Box 68	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	l déath 3[	□Ectopic pr □ Other (sp					23	3d. Date of de Month	livery Day Year	
	signed signed d be de	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying c	ause give	n in Part I.			-		o the cause of death?	'n
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Vital	ysicien: ] is certifical director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆	ER/Outpatie	nt 3 DO	Othe	a Pri		(Check only only only only only only only only		Other (Spe	ocify)	
Division of	ling Ph	ation; T	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigat		ury a <i>y Year)</i>	28b. Time o Injury		8c. Injury Work		2	8d. Describe l				
Divis	in the c	Certification:	3 Suicide 6 Could not determine	d 28e. Place of II building, e	tc. (Specif)	/) 					City or Tov	vn, State)		ura i Route Number,	
	the H nin 24 the F nplete	Medical	(Check only 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examinat	wledge, deat tion and/or in	vestigation,	at the tim in my op License	inion, deat	d place, a th occurre	ed at the time,	date and p	place, and du	to the cause(s)	
)	5 will ro		29b. Signature and title of certifier	mella	M-O		a		412			May	og h	a roly,	
	4		The State of the S	HTA, M.I	7	601 0	SLER		IVE,	TOV	ISON,	MARY	LAND	21204	
:0	Sta Registr		MAY 1	1 2004 A	Larve	, with	Spa	de	4						

State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar 1-Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death ne (If not institution, give stre Examiner 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 F Director the Maryland 10a. State 10b. County City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No **Funeral Director** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ Road or ferms 23a Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐ Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: lack Completed by 3 Widowed 4 ☐ Divorced "naturaf" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) mportant: If item 27 is marked other 17, Father's Name (First, Middle, Last) Pages 1 and 2 should be Department of Health and Mental 19b. Mailing Address (Street an Baltimore, Method of Disposition Burial 2 Cremation 3 Removal from State Injury or Memoria 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any ir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) MYOCARDIAZ **Physician** INFARCTION MINUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a shed for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 🗆 No 3 Probably 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: J 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours of To the Funeral Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 2604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 80 TIMORE 31. Date filed (Month 82. Registrar's Signature State Registrar

hee WILLIAI		For State Registrar	State of Maryla	and / Dep	idelible Ink. Ensur artment of Health ar rtificate of Death	nd Mental Hygi	ene2 () () (;	1499
Physiciar /Medica	_	1. Decedent's Name (First, Middle, La:	EECHAE	7.	WILLIAMS	2. Date of Death Month May 03,	2004 Year	3. Time of Death 2325P.
Examine		4a. Facility Name (If not institution, given Johns Hopkins Ho			4b. City, Town, or Location of D	Death	4c. County of Dear	h
Funeral Director		5. Social Security Number 6. S 217 · 54 · 802 5 1	-	rs. last birthday, Yrs.	If Under 1 Year If Under 24	Hrs. 8. Date of Birth Min. Month, Day,	9. Bir 5, 2000 M	hplace (State or Foreign the NO
e Maryland le-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD	10c.	City, Town or Li	ocation MORE			10d. Inside City Limit
eath with the	erai Dire		" STREET		10f. Zip Code 212/8	3	g. Citizen of What Co	A.
1215-0036 within 72 hours after death with the Maryland ene. then "naturel, or Items 23a or 28e-1 show the Madical Examiner must be notified at manifed by Europeal Disorber	a by rune	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 Moo If Yes, Give Year or Dates:		Was Decedent of Aispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit Specify: BL	ncan Indian, e, etc. ACK
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28e-1 show eny injury or other traumatic event, the Modical Examinat must be notified at once.  TO Be Completed by Europea Discrete.	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired) INFANT	working 16	6b. Kind of Business/	
Vland Suld be filed Mental Hygarked other atic event.	e e	17. Father's Name (First, Middle Last)	nero		18. Mother's	Name (First, Middle, Ma	aiden Sumame) W/U/A	rms
and 2 sho ealth and m 27 is m	(	19a. Informant's Name/Relationship (I	S MOTHER	R 408	ng Address (Street and Number of E. 30th Str		City or Town, State, 2	
Baltimore, bermit. Pages 1 a Department of Hes Importent: If item iny injury or othe		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	RK WOOL	Tractory or other place)  Cometery 5	.10.0+ p	ARK VILLE,	MARYLAN
Depa Depa Impo eny is		21. Signature of Funeral Service Licen  Vacy	r drue	4	2. Name and Address of Facility (	quatin c. Gi D Bautin	CEENE FUN CEE. WARY	LAND 21212
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	e inju				Approximate Interval Between Onset and Death
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8760, ate be exec hysician an the burial-tr	Č	resulting in death) Last	Due to (or as a cons	equence of):				
, P.O. Box 68760, that the death certificate be exe od by the attending physician a detached for use as the burian. Physician/Medical Ex	yalolali mo	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of prec 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of delin	very Day Year
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F Vita ysicien: ysicien: is certific director,		25. Was case referred to medical examiner?  1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatien	Oth	Death <i>(Check only one)</i> g Home 5 Residenc	e 6 □Other (Speci	fy)
<u> 등 후 품의 1</u>		27. Manner of Death  1 □ Natural 5 □ Pending 2 ☞ Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe how	injury occurred	vehicle
ion of ding Ph th. : After thi funeral			THE PARTY OF THE P	10:13		,	see dell	
Division of Vital Records, P.O. Box 68760, othe Hospitel or Attending Physicien: The law requires that the death certificate be executed thin 24 hours after death.  The thin 24 hours after death.  The thin 24 hours after death.  The thin 24 hours after death.  The thin 24 hours after death.  The thin 24 hours after death.  The thin 24 hours after thin 24 hours are the buriat-transit or the thin 24 hours at the buriat-transit medical Certification: To Be Completed by Physician/Medical Examin		2 ✓ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Pace of Injury - At building, etc. (Spec	home, farm, stre city) Streat		28f. Location (Stree City or Town, S 4800 Blocu	et and Number or Rur State)	al Route Number,

Division of

To the Hospitel or Attending Phys. within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire

State Registrar

29c. License number O.C.M.E.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) May 04, 2004

Jessha 2 Greense Mp

30. Name and address of person who completed cause of death (New 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Tasha ZGreenberz M.D.

31 Date filed (North, Day, Year)

MAY 1 1 2004

Service Signature

			1- For State of Maryland / De Registrar	partment of Health and Nertificate of Death	ental Hygidا Reg	ene2004 14992	
	Physic	ian	Decedent's Name (First, Middle, Last)  ANDRZEJ WASICKI		2. Date of Death Month	Day Year 3. Time of Death	
>	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 8, 2	4c. County of Death	
		ш	Easton Memorial Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthd)	Easton  If Under 1 Year   If Under 24 Hrs.		Talbot	
	Funeral Director		214-08-8607 1XIM 2 F 48 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Y JULY 1	9. Birthplace (State or Foreign Country)  9. POLAND	
	yland sow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits	
	e Mar	Funeral Director	MD. HOWARD ELLI	COTT CITY		1 □ Yes 🤾 💢 No	
	with th	Dire	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?	
	ns 23	erai	8694 MANAHAN DRIVE  11. Marital Status 12. Was Decedent Ever in U.S. 1	21043  3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	U.S.A.  14. Race - American Indian,	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I health and Mental Hygiene. I health and show them 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avent, the Medical Examinations.	by	Amed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Pueric 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc.  Specify: WHITE	
215-0036	72 ho 'natur	eted	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work	sing 16	b. Kind of Business/Industry	
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	e filed Il Hygi other	To Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
Maryland	ould by Menta arked		JAN WASICKI	JOANNA	CZACZI	<b>Κ</b> Α	
Mar	12 sho h and 7 Is m traum			tiling Address (Street and Number or Rui			
	s 1 and f Healt item 2 other		20a. Method of Disposition 20b. Place of Dis	position (Name of		CT CITY, MD. 21043 c. Location - City or Town, State	
OE .	Pages nent of ant: If i		I Durial 2 Acremation 3 Demondration State	rematory or other place) CREMATORY 5/12	/04 E	BALTIMORE, MARYLANI	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic avent, I'm I'm Once.		21. Signature of Funeral Solvice Licensee	Z Name and Address of Facilities 1901 EASTERN AV	INC. FUN	NERAL HOME	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and Death	
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68760,	icate be executed physician and the burial-transit	aiE	Bud to (or as a consequence on).				
-		Aedicai	U				
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as t	Physician/M		3□Ectopic pregnancy		23d. Date of delivery  Month Day Year	
0.	that the der ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month Day 16a	
Ω.	res that the signed by to be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?	
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Records,	e lawr has be je 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
alF	ician: The certificate ha				performed 12 Yes 2		
Vital	Physician: this certificanal director,	To Be	25. Was case referred to medical examiner?  1 ★ Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpat	Othor	n (Check only one) me 5 ☐ Residenc	e 6 □Other (Specify)	
n of			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at	28d. Describe how		
Division	r Attending er death. rector: After by the fune	catio	2 Accident investigation 5/8/04 8:00	PM 1 Yes 2 No	Subject	nongepet	
Divi		Certification;	determined    28e. Place of Injury - At home, farm, building, etc. (Specify)		et, factory, office  28f. Location (Street and City or Town, State)  123i 8 Green Shi		
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical C	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, de (Check only one) 2 ☑ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, dete and place.	and due to the caus	e(s) and manner as stated	
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)	
	$\wedge$		1 (Ubo tens)	OCME	Mã	ay 9, 2004	
	8		30. Name and address of person who completed cause of death (Item 23a) (Type Table 1)	111 Penn Street	, Baltimo	ore, Maryland 21201	
	* Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	MAY 1 1 2004 A A	M. a			

	,		1 - For Registrar	State of Marylar	nd / Department of Certificate of		Mental Hygien	2001 1100
	Physici /Medi	cal	1. Decedent's Name (First, Middle, La		Wagsta		MRY :	Year 7 2004 10 38 AM
	Examir	ner	4a. Facility Name (If not institution, given by the plants of the plants	Huspital	last birthday) If Under 1 Year		8. Date of Birth	c. County of Deeth  9. Birthplace (State or Foreign Country)
6	Director		Usuel Residence of Decedent  10a. State  10b. County	P	ty, Town or Location		June 19,1	10d. Inside City Limits
	with the Ma la or 28a-f s	Director	10e. Street and Number	on Original	10f. Zip Code	21218	10g. C	1 TYes 2 No
36	72 hours after death with the Maryland netural', or Items 23a or 28a-1 show dral Examiner out the notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of If Yes, specify Cult		ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White etc. Specify:
21215-0036	i within 72 hours liene. r then "netural", ins Madical Ex	Completed t	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work.	ing 16b.	Kind of Business/Industry
Maryland 2	be filed htal Hyg hd othe event,	To Be Co	17. Father's Name (First, Middle, Last,	int	Ffine	18. Mother's Name	e (First, Middle, Maide	n Sumame) Likell
a)	1 and 2 Health a om 27 is ther tra	0	19a. Informant's Name/Relationship (	n Charlier	19b. Mailing Address (Stree)  260/ A  Place of Disposition (Name of	Deltin	un Stree	or Town State, Zip Code) 2120/ Dulbing YD  Location - City or Town, State
Baltimor	ermit. Pages epartment of I nportant: If it ny injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specifications) 21. Signature of Funeral Service Licer	Removal from State	cometery, crematory of other place.  22. Name and Address	ery May	8,2004 La	arelowie HD
Ę	Physician /Medical		23% Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line.  a.  Due to (or as a consequence)		Such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
8760,	Examiner  and  and  al-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Recta Due to (or as a conseq c. Due to (or as a conseq d.	1 Perferation	n		2 weeks
. Box 6	death certific e attending p ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 Ectopic pregnanc	у		23d. Date of delivery Month Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions c	ontributing to death but not res	ulting in the underlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to the cause of death?
<u>ж</u>	The ate h page	e Completed	os W				24a. Was an autopsy performed? 1 ☐ Yes 2 🔀 No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
of Vital	Physician: this certificanal director,	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) No	Hospital: 120npatient 20	ER/Outpatient 3 DOA	26. Place of Death	(Check only one) me 5 ☐ Residence	6 Other (Specific
Division of	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wor	ry at 2	28d. Describe how inju	
Dİ	pital or Att		4 Homicide determined	building, etc. (Specify			City or Town, State	
	te Hos 24 hc te Fun letely	edical	(Check only one)	niner: On the basis of examina and manner stated.	wledge, death occurred at the tit tion and/or investigation, in my o	me, date and place, a opinion, death occurre	and due to the cause(s ad at the time, date an	) and manner as steted. d place, and due to the cause(s)
)	To th To th comp	Me	29b. Signature and title of certifier	. Sorhe, A		Se number		y 7, 2004
Tr.	Sta	te	30. Name and a sess of person who did you E. Lock 31. Date filed (Month, Day, Year)	2, M.D. 60 32. Registrar's Signa	00 North Wolfe	e Street,	Baltimore	e, MD Z/287-9100

			1 - For State Registrar	State of Ma	arylan	-	artmen <i>tificate</i>				-	giene Reg. No	00	04	14994
	Physici	ian	Decedent's Name (First, Middle, Last)			_					2. Date of De Month	ath Da	y	Year	3. Time of Death
10	/Medi	cal	David Sim		stoc	k					May	11,	_20	04	5:00 A <sup>M</sup>
4	Examir	ner	4a. Facility Name (If not institution, give : 111 Hamlet Hill		n t	1002			Location o	of Death		4c.	_	of Death	
	Funeral		5. Social Security Number 6. Sex			last birthday)	If Under	tim 1Year	If Under	24 Hrs.	8. Date of Bir	th		A Birtho	lace (State or Foreign
	Funeral Director				95	Yrs.	Months	Days	Hours	Min.	FEB 6,	y. Year)	)9	New	York
	D		Usual Residence of Decedent												
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show mith proposent: If item 27 is marked other the "netting of the indifficial approxe. Indifficial at page.	_	10a. State 10b. County Maryland N/A			y, Town or Lo timore								1	0d. Inside City Limits
		ecto	10e. Street and Number		Dai	CTHOLE		0.1				10 0			1 Yes 2 □ No
	a or 3	ā	111 Hamlet Hill Ro	ad #1002			10f. Zip 212					USA		Vhat Cour	ntry?
	ns 23	Funeral Director		12. Was Decedent	Ever in U.	.S. 13. V	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e			ecify Yes or No			e - Americ	an Indian,	
60	or Iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give						, Puerto	Rican, etc.)			k, White,	etc.
5-0036	rel', c	l by	3 ₩idowed 4 Divorced	If Yes, Give 23 Year or Dates:		1	I□Yes 2	∑XI No	Specify:				Specify	<i>'</i> :	White
5-0	72 h	Completed	15. Decedent's Edu- (Specify only highest grade			16a. Deced	kind of wor	k done d	uring most	of worki	ng	16b. K	. Kind of Business/Industry		
121	within sne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Contr	OO NOT us					Trol-		_	
d 2	Hygie ther	ပိ	17. Father's Name (First, Middle, Last)	4		COLLET	orrer		18. Mothe	r's Name	(First, Middle,		OACC(		
Maryland 2121	12 should be filed within h and Mental Hygiene. 7 Is marked other then "ireumatic event, the Med	To Be	Simon Weinstock Carrie Jovesoph												
ary	shou and N	-	19a. Informant's Name/Relationship (Type	oe, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	I Route Numbe	er, City o	r Town,	State, Zip	Code)
	1 and 2 Health tem 27 I		Betty Parker/Dau	ghter		210 L			Road	В	altimor	e, M	1D 2	2 <b>121</b> 0	)
ore	of He of He fiter		20a. Method of Disposition 1 ☐ Burial 21☑ Cremation 3 ☐ R	emoval from State	a	lace of Disposemetery, crem	natory`or ot	her place			ate	20c. Lo	cation -	City or To	wn, State
Ë	Pages tment of t tent: If ite		`4 □Donation <sup>2</sup> 5 □ Other (Specify)		Met	ro Cre	mator	y In	ic. į	5-11	-04	Bal	timo	ore,	MD
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Euneral Service Oceanse	ie		Ç	. Name and	d Addres	Society Society	ety_c	of MD Ba <b>l</b> t	Inc.			
	40260	$\square$	Thomas Gregor ( 23a. Part1. Enter the disease, or compli	pations that caused	the death								e, 1	$^{4D}$ 2	1228 Approximate
	= 1		shock, or heart failure. List only or Immediate Cause (Final	e cause on each in	10.										Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to for as	a consequ	uence of):	on thy								4 years
	Examiner			athers:	selen	otiv s	ardis	Jase	ular	d	is eas e	_			
	D .=	je	Sequentially list conditions, in any, issuing to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se	a consequ	aerica of <i>j</i> .									
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last												
8760,	cate be executed bhysician and the burial-transit			Due to (or as	a consequ	uence or):									
387	physics the	dic	d								<del></del>	-			
9 xo	eath certific attending pl for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome									23d Date	e of delive	rv.
ă	death e atter	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pre Other (spe						Mor		Day Year
P.O	it the de by the tached	hys	9 Unknown	9□ Unknown											
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	<b>by</b> P	Part II. Other significant conditions con	tributing to death b	ut not resu	ulting in the un	derlying ca	use give	n in Part I.						e cause of death?
ord	w requir been si should		my el od y splas:	λ							101	'es 2[	J No	3 Prob	ably 4 Unknown
Vital Records,	e law has b	Completed	chron,2 renal	insuffi	URBIL	7					24a. Was autop	sy	p	rior to con	osy findings available appletion of cause of
al F			harpes zis	ter								med? 2 No		eath?	2□ No
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:		5010	-57.00	Othe			(Check only o				
ō			1 Yes 2 No	1 ☐ Inpatie	ry	ER/Outpatient 28b. Time of		Bc. Injury Work	4 🗀 1401		ne 5 Resid				)
lon	를 는 물 것	to	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М		? es 2.∏.N	No					
Division	l or Attendii after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju-			et, factory,	office		2	28f. Location (S City or Tow			er or Rura	Route Number,
Ö	ospitel or A hours after unerel Dire ly filled in by	Cer		Duliding, etc	o. (Openly						Ony or Ton	m, olate,			
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	ician: To the best of er: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurred a estigation,	it the time in my opi	e, date and inion, deat	d place, a h occurre	and due to the ded at the time, o	ause(s) date and	and mar place, a	ner as stand due to	ated. the cause(s)
	To t To t com	Σ	29b. Signature and title of certifier					License							Day, Year)
,	2		Minh 12	men p	9		1	00	591	89		, /	4/	04	
	1		30. Name and address of person who co				Print)	0	17	•	e mo				
			31. Date filed (Hepthy Day Year)	22. Registra		1. 40 th	1 28	15	alt	י איני מי	e mo	i	124		
	Sta Registr		MAY 1 1 2004	Serve	ر	4	loons	61							

		For State Registrar	State of Marylan	d / Depa		ealth and M	lental Hyg	•	4 14995
Physic /Med Exam	ical	Decedent's Name (First, Middle, La     Carlton Beverly     Aa. Facility Name (If not institution, give	ASHWORTH		4b. City, Town, or	Location of Death	2. Date of Dea Month	Day Year  Ac. County of Dea	3. Time of Death  900 M  Ath
Funera Directo		11 Lehigh Street 5. Social Security Number 6. S			Hagers If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 3	Washing	,
1215-0036 within 72 hours after death with the Maryland ane. Then "natural", or Items 23a or 28e-1 show a Medical Exeminant to notified at	ral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Washing  10e. Street and Number  11 Lehigh Avenue	ton		rstown 10f. Zip Code 21742			10g. Citizen of What C	•
-0036 2 hours after de atural', or Itemi	ted by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	12. Was Decedent Ever in U. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1951-	-59	Was Decedent of His f Yes, specify Cubar I Yes 2 No lent's Usual Occupa kind of work done d	Specify:		Specify:	te, etc. White
	Be Completed	(Specify only highest grade Elementary/Secondary (0-12)  5  17. Father's Name (First, Middle, Last,	College (1-4or 5+)	life. I	kind of work done d DO NOT use retired; cuck Drive	er		Trucking Maiden Sumame)	
re, Maryland 2 st and 2 should be filled Health and Mental Hygi tem 27 is marked other	Tof	Samuel Allen Ashv 19a. Informant's Name/Relationship ( Dearl Haines - St	Type, Print)		-		il Route Numbe	reasey r, City or Town, State, own, Maryl	
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tre		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer	Removal from State Cec	emetery, cren lar Lav	sition (Name of natory or other place on Mem. Page 1).  Name and Address	ark 4/28/		20c. Location - City or Hagerstown Funeral Ho	, Maryland
M BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line.		15 E. Will: er the mode of dying			est, Md.	Approximate Interval Between Onset and Death
760, te be executed ysician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	ywet	id Polin	y 018x	38E*		
O. Box 6. ne death certificate the attending part of the death of the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
cords, P.	<b>6</b>	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause give	n in Part I.	1 🗆 Y		robably 4 🗆 Unknown
Vital Recilicien: The law	Be Completed	25. Was case referred to medical				26. Place of Death		med death? 2 ☑ No 1 ☐ Yes	utopsy findings available completion of cause of
n of ng Phys	Certification: To E	examiner?  1 Yes 2 No  27. Manny of Death  1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Dete of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work M 1 \( \text{Y}	at ?	28d. Describe h	ence 6 Other (Spe	
Divisio  To the Hospitel or Attendit within 24 hours after death.  To the Funerel Director: A completely filled in by the fu		4 Homicide determined		viedge, death	occurred at the time	e, date and place,	City or Town	ause(s) and manner as	stated.
To the H within 24 To the F	Medical	29b. Signature and title of certifie	and manner stated.		290 License			9d. Date signed (Mont	``
THAT!		30. Name and address of person who	completed cause of deal (Item)	VII	Crint) / 2/	We Hay	ustour, c	218 31998	
S Regis	ate trar	ST. Date filed (Month, Par) 1947	004 See gogistar's signat	G. Sy.	arke	/			

	1 - For State Registrer	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie	ne 2004 1499
Physician /Medical Examiner	berryn Carvin Ath	erton, Sr.	4b. City, Town, or Location of De Hagerstown	April	Day Year 3. Time of Death  23 2004 /6/0 M  4c. County of Death  Washington
Funeral Director	5. Social Security Number 6. Sec. 218-24-8434 12 Usual Residence of Decedent 10a. State 10b. County	7. Age (In yrs. last birthday 7. Age (In yrs. last birthday 74  Yrs.	Months Days Hours Mi		ar) 9. Birthplace (State or Foreign Country) WV
6 after death with the Maryl or items 23a or 28a-f sho riner must be notified.	MD Washingt 10e. Street and Number 11 W. Baltimore S	on Hagersto		10g.	10d. Inside City Limits 1 √ Yes 2 □ No Citizen of What Country? USA
and 21215-UU30  be filed within 72 hours after death with the Maryland that Hygiene.  ed other than "natural", or items 23a or 28a-1 show avant, the Mudical Exartinar must be notified at Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 🛣 No Specify:	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Maryiand 21215-0036 Id 2 should be filed within 72 hours att Ith and Mantal Hygiene. 27 is marked other instural; or traumetic avant. If a Mudical Exart To Be Completed by F	15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12)	de completed) (Give life.	edent's Usual Occupation e kind of work done during most of w DO NOT use retired) IVer	orking	Kind of Business/Industry  Faxi Services
aryig should and Mer s marks sumetic	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid Pauline Ha: Bural Route Number, Cit	rtman
the are	Theresa P. Vaughn  20a. Method of Disposition  1	Removal from State 20b. Place of Disposementery, cre	matory or other place)	Date 20c.	astle, PA 17225  Location - City or Town, State  gerstown, MD
Definition  permit. Pages Department of F Important: If Its eny injury or of	21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complete	99 / 2	2. Name and Address of Facility (305 N. Potomac St	Gerald N. Mi reet, Hage	innich Funeral Home
ificate be executed g physician and as the burial-transit edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Lister University that initiated events resulting in death) Last	1	nal Falure		Interval Between Onset and Death
death certiing a attending of for use a iclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
es ti gna be c	Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?
	25. Was case referred to medical		26 Place of De	24a. Was an autopsy performed? 1 Yes 2 N ath (Check only one)	24b. Were autopsy findings available prior to completion of cause of death?  o 1 □ Yes 2 □ No
To To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☑npatient 2 ☐ ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	t 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence 28d. Describe how inju	
To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After templetely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physics	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)  sician: To the best of my knowledge, death	Occurred at the time, date and place	City or Town, Star	
	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. Do	ate signed (Month, Day, Year)
State Registrar	Dr. Murshed	mplered cause or death (item 23a) (Type, 1/2 6 0 pcl 32. Rep trans Signature	Court, Hog.	nd	-

			1 - For State Registrar	State of Maryland		ent of Health and cate of Death		giene Reg. No.2004   4997
	Dharata		1. Decedent's Name (First, Middle, Las	t)		-	2. Date of Dea	ath 3. Time of Death
	Physici /Medi		MARY	VIRGINIA A	ALBERT		April	23, 2004 3:45 AM
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. 0	City, Town, or Location of D		4c. County of Death
			Frederick Memo	orial Hospita	1	Frederick		Emadanial
	. Funeral	П	5. Social Security Number 6. Se	7. Age (In yrs. last	birthday) If U	nder 1 Year   If Under 24 I		Frederick  h 9. Birthplace (State or Foreign Country)
	Director		215-26-7856	□M 213 F 79	Yrs. Mon	ths Days Hours N	July 10	, 1924 Maryland
	pu »		Usual Residence of Decedent					, =>= , ====
	72 hours after death with the Maryland natural', or tlems 23a or 28a-f show Jical Execulted natified at	-	10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits
	Ba-f	ct	Maryland Frederi	ck Bruns	swick			1 ☑Yes 2 ☐ No
	ith th	ire	10e. Street and Number		10f	. Zip Code		10g. Citizen of What Country?
	th w 23a	Funeral Director	13 North Virginia	Avenue		21716		United States
	dea sme	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was D	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - American Indian,
9	or ft	교	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		***	ieno Rican, etc.)	, , , , , , , , , , , , , , , , , , , ,
8	raf,	d by	3 XWidowed 4 □ Divorced	Year or Dates:	1 LI YE	s 21 No Specify:		Specify: White
21215-0036	u within 72 hours after death with the Marylar liene. r than "natural", or flems 23a or 28a-f show It e Moural Expolled or untile on tilling a	Completed	15. Decedent's Edi (Specify only highest grad	ucation 16	Sa. Decedent's I	Jsual Occupation work done during most of	anortrin a	16b. Kind of Business/Industry
21	E . c .	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	Tuse retired)	WORKING	
21		Ö	10		Home	emaker		Own Home
pu	N 2 2 3	Be	17. Father's Name (First, Middle, Last)			18. Mother's h	Name (First, Middle,	Maiden Sumame)
<u>X</u>		ဥ	Edward Lee Eur	у		Rosie	Lee Payn	e
Maryland	C1 00 -00 45		19a. Informant's Name/Relationship (T	ype, Print)	9b. Mailing Add	ress (Street and Number or	Rural Route Number	r, City or Town, State, Zip Code)
	1 and Health am 27		Mary Lee Cossairt	/ Daughter 8	507 Nor	thumberland l	Dr., Delma	er, MD 21875
Ze	of Hear		20a. Method of Disposition	20b. Place	of Disposition (	Name of		20c. Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	ionioval irolli olalo		Cemetery	il 26,	Description of a law Married and
Œ	mit. Pa partmen cortant: injury injury		21. Signature of Futher J Samuel Lings	Idik	22 Name	and Address of Facility	The state of the s	Brunswick, Maryland
ä	permi Depa Impo any i		795		Resth	aven Funeral	Services,	Skkot Cody P.A. derick, MD 21701
			23a. Party. Enter the disease, or composhock, or heart failure. List only o	lications that caused the death. Do	o not enter the r	node of dving, such as card	ac or respiratory arr	est, Approximate
			shock, or heart failure. Its only o	ne cause on each line.	17	- A	A	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Chrome	Glibra	chie Du	dura	Le mangegears
	Examiner			Due to (or as a consequence	e of):	-	/	0 0
	ys -1 t+	0	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	e off:			
	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury	Duo to for as a consequence	e org			
	te be executed ysician and te burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequence	e of):			
9	be e ician buria	calE		200 (0) 20 2 001100400100	3 31).			
68760,	eath certificate be executed attending physician and for use as the burial-transit			d				
9 ×	ding	/Me	IF FEMALE:	170 16 100 0		7	- Carr	
Вох	ath o	ian	200. Was decedent pregnant	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal deat		pregnancy		23d. Date of delivery
o O	the a	sic	in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 🗌 Other	(specify)		Month Day Year
P.O.	that the death	by Physician/Med						
Ś	ires tha signed b		Part II. Other significant conditions cor	()	in the underlyin	g cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
	3 00		1 1	my come	40			
ord	nog	te					1 □ Ye	s 2 ☐ No 3 ☐ Probably 4 🕱 Unknown
ecord	taw requir as been si 2 should	pietec		)	~		24a. Was ar	24b. Were autopsy findings available
Record	The law requate has been page 2 shoul	completed		)			24a. Was ar autops perform	24b. Were autopsy findings available prior to completion of cause of death?
ital Records,	ian: The law requirificate has been stor, page 2 shoul	3e Completed	25. Was case referred to medical	)		26. Place of D	24a. Was ar autops perform 1 □ Yes	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
f Vital Record	ysician: The law requise certificate has been director, page 2 shoul	o Be	eddining!	lospital: 1928 Inpatient 2 ☐ ER/O	Outpatient 3	Other	24a. Was ar autops perform 1 Yes	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
າ of Vital Record	ysician: The lar is certificate has director, page 2	To Be	1 ☐ Yes 2 No F	28a. Date of Injury 28b.	Time of	DOA Other: 4 Nursing 28c. Injury at	24a. Was ar autops perform 1 Yes	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  nce 6 Other (Specify)
ion of Vital Record	nding Physician: The law requath. r: After this certificate has been e funeral director, page 2 shou	To Be	1 ☐ Yes 2 No	28a. Date of Injury 28b.		DOA Other: 4 Nursing	24a. Was ar autops; perform 1  Yes eath <i>(Check only one</i> Home 5  Reside	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  nce 6 Other (Specify)
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	1 - State Registrar	tate of Maryland / Depa	artment of Health and rtificate of Death	Reg. N				
Physician /Medical	David	William	Barnhart	April Q	4 2004 3:25 P.M			
Examiner Funeral	Washington County H 5. Social Security Number 6. Sex	ospital 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Dea Hagerstown If Under 1 Year   If Under 24 Hrs Months Days Hours Min	8. Date of Birth (Month, Day, Yea				
Director	213-18-8385	10c. City, Town or Lo	ocation	Dec.28,192	10d. Inside City Limits			
or 28e-f st	MD Washington  10e. Street and Number		1 N Yes 2 No					
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23e or 28e-f show other treumstic event, it we Medical Evertimet at must be notified at To Re-Completed by Filmeral Director		1X1Yes 2 □ No 1942-	21740 Was Decedent of Hispanic Origin? (; If Yes, specify Cuban, Mexican, Pue		U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White			
ed within 72 hou ygiene. The "nature then "nature to "n	15. Decedent's Educati (Specify only highest grade co	on 16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) fitter	orking	Kind of Business/Industry			
should be filed with and Mental Hygiene, marked other the umatic event, the To Re Comm	17. Father's Name (First, Middle, Last)	•	18. Mother's Na Viola F	me (First, Middle, Maide I • Long	on Sumame)			
1 and 2 sho Health and 1 lem 27 is me	19a. Informant's Name/Relationship (Type, Cheryl E. Socks/Daug	hter 84 Pe	ng Address (Street and Number or A	.11e, VA 22	2610			
permit. Pages 1 Department of H Importent: If ite any injury or ott	20a. Method of Disposition  1 🕅 Burial 2 □ Cremation 3 □ Rem  '4 □ Donation 5 □ Other (Specify)	Rest Have		/2004 Hag	erstown, MD			
Departiment in permit in p	21. Signature of Funeral Service Licensee	16	2. Name and Address of Facility R 501 Pennsylvania ter the mode of dying, such as cardia	Ave. Hagers				
Physician /Medical	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	ause in each line.  CACHE > 1 A  Due to (or as a consequence of):		o or respiratory arrest,	Interval Between Onset and Death HoM HS			
	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. ATKEROSCEROS (S)  Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.							
death certified attending of for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year			
8 20 6	ARRONIAL	uting to death but not resulting in the u		23e. Did tobacco	use contribute to the cause of death?  2 No 3 Probably 4 Unknown			
The law ate has b page 2 sl			OC Plans of Do	24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death?  1   Yes 2   No			
tending Physics to: After this the funeral di	examiner? 1 Yes 2 100 Hosp	oital: 2 ☐ ER/Outpaties  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Place of Injury - At home, farm, st	ont 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No	Home 5 Residence 28d. Describe how inj				
		building, etc. (Specify)  an: To the best of my knowledge, deat	h occurred at the time, date and plac	City or Town, Sta	s) and manner as stated.			
To the Hosp within 24 hou To the Fune completely fil	(Check only 2 Medical Examiner one)  29b. Signature and title of certifier	On the basis of examination and/or in and manner stated.	29c. License number		ate signed (Month, Day, Year)			
5H-641	30. Name and address of person who comp	leted cause of death (Item 23a) (Type,	Print) 00 /60	T dan no	2			
State	31. Date filed (Month, Path Year 6 2004	32. Segistrar's Signature	ale por					

			1 - For State Registrar	State of Maryla	•	artment of F			giene 0	04	14999		
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death		
2	/Medic		RICHARD WILL			1. 05 T	-11	April 2	-		4,40 PM		
	Examin	er	4a. Facility Name (If not institution, give s Frederick Memoria			4b. City, Town, o		Death	4c. County	erick			
	Funeral		Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birt		9. Birthp	lace (State or Foreign		
	Director		219-30-7933	M 2□F 62	Yrs.	Months Days	Hours 1	Hrs. 8. Date of Birt (Month, Day 5-22-	1941	Wash	ington,DC		
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				1	Od. Inside City Limits		
	Maryl	tor	Maryland Frederic	k Mo	onrovia						1 ☐ Yes 2X No		
	filed within 72 hours after death with the Maryland Hygelen. Uther then "naturel", or Items 23e or 28e-f show ent, Ita Medical Examinatina Enrollited at	i Director	10e. Street and Number 4965 Tall Oaks Dri	ve		10f. Zip Code 21770					Citizen of What Country? United States		
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin	? (Specify Yes or No-		e - Amend			
9	or Ite	y Fu	1 Never Married 2 X Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	done moun, do.,		v: Whi			
Š	hours turel	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of B				
7	n na n na	piet	(Specify only highest grade		(Give	kind of work done of DO NOT use retired	during most of	working	TOD. KING OF D	J3111033/1110	dustry		
212	d with giene giene er the	Completed	Elementary/Secondary (0-12)	5+	Ph	ysicist			Dept.	of De	fense		
Maryland 21215-0036	uld be file Mental Hy rked oth tic event	To Be C	17. Father's Name (First, Middle, Last) Richard Wilson Br	Name (First, Middle, abeth Dugar	me (First, Middle, Maiden Sumame) eth Dugan								
lary	2 shot and h is ma		19a. Informant's Name/Relationship (Type			•		r Rural Route Numbe		State, Zip	Code)		
<u>√</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. The most are the marylar and then then "naturel", or items 23e or 28e-4 show any injury or other treumatic event, the Medical Examinar must be notified at once.		Barbara H. Brown/W		4965 b. Place of Dispo		ks Dr,	Monrovia,		770	Chale		
Baltimore,			20a. Method of Disposition  1 🕅 Burial 2 ☐ Cremation 3 ☐ Ro  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crei arklawn	natory or other place	(e) 4-	-28-2004	Rockvi	-			
Balt	permit. Departr Importu any inji		21. Signat re of Fune al Service License	William	$\mathcal{L}$ $\begin{vmatrix} 2 \\ 0 \\ 2 \end{vmatrix}$	Name and Address 1in L. Mo 6401 Rids	ss of Facility Deswor ge Road	th, P.A. I	Funeral	Home 20872			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. A text os the cardiac Cardia										
F	nysician	ď. N	Immediate Cause (Final disease or condition	Arterios	clorati	c Card	لحاصنا	salar (	h scar	2	Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a cons							/		
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8760,	icate be executed physician and s the burial-transit	dicai											
9 X	eath certific attending p	0	IF FEMALE:	3c. If yes, outcome of pre	gnancy				23d Dat	23d. Date of delivery			
Вох	death atten	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 🕅 No	1 Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			Mo		Day Year		
o.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown									
rds, P.	w requires tha s been signed I should be det	Ď	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	_	ribute to th 3 ☐ Prob	e cause of death? ably 4 \textcal{\textcal{D}} Unknown		
900	aw rec	Completed						24a. Was a			osy findings available inpletion of cause of		
Ě	The ate has page	E OC						perfor	med?	leath?			
/ita	cien:	Be	25. Was case referred to medical examiner?	ocnital:		Lon		Death (Check only or	10)				
of o	Physi this or	<u>۲</u>	1  Yes 2 No	ospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatier 28b. Time of		4 L Nursir	ng Home 5 Resid			"		
O	ding th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year	) Injury	Worl		200. 00001100 11	on injury occurr	00			
Division of Vital Records,	l or Attendi after death Director: A	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office			181. Location (Street and Number or Rural Route Number, City or Town, State)				
_	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death.  Vot he Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical Ce		slcien: To the best of my liner: On the basis of exame and manner stated.									
	o the outhin to outher outher outher	Mec	29b. Signature and title of certifier	1	^	29c. License	a number	2	9d. Date signed	(Month, L	Day, Year)		
	- s - ō		& mow +	M	)	D.	3516	4 A	c lings	7,2	004		
	1 , i		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type,	Print)		f A			12201		
	14		Andrew ZA	RICK, JY	, MD	15 Wes	7 /	, 24, tr	eceri	4, N	MICINI		
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 8	32. Registrar's Sig	gnature	is do	ach!	•					

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #21 PER FH C831 5/11/04 CHErtificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month WILLIAM JENNINGS BAXTER  $\mathbf{P}^\mathsf{M}$ MARCH 20 2004 8:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDET. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months 1 X M 2 □ F Director Yrs 218-48-6853 56 FEB. 29, 1948 MARYLAND Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo MD QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 1 5 itams 23a 606 DOMINION DRIVE 21619 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 5 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other treasment." Elementary/Secondary (0-12) College (1-4or 5+) 10 PILE DRIVER MARINE CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be SAMUEL JENNINGS BAXTER HILDA MAE STERLING 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA BAXTER/WIFE 1501 STARR RD., CENTREVILLE, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BAXTER FAMILY CEMETERY 03/25/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) CHESTER, MD 21. Signature of Funeral Service Licensee PER DVR FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 FELLOWS, RYAN R. HELFENBEIN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acclia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Box 68760 Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for u 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No the a 9□ Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 3 🗌 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an has le 2 autopsy page ; certificate 2 No 1 Yes Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 Inpatient 2☐ER/Outpatient 3☐ DOA this After thi 28a. Date of injury (Month, Day Year) 27. Mannet of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after deatl To the Funeral Diractor: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à determined 4 Homicide ö Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number CHOTAL 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADITYA CHOPRA, 600 RIDGELY AVE., ANNAPOLIS, MD 31. Date filed (Month 32. Registrar's Signature State 5 2004 Registrar